IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2004 2249

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JANE HENDTLASS, Coroner having investigated the death of GAYLEE ANTILLIA KATI

without holding an inquest:
find that the identity of the deceased was GAYLEE ANTILLIA KATI
born 19 May 1963
and the death occurred on 28 June 2004
at outside 23 Closeburn Avenue, Prahran East 3181
from:

1 (a) CRUSH INJURY TO THE CHEST

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Gaylee Antillia Kati was 41 years old when she died. She lived with a flat mate, Shane MacLennan, at 67 Watt Street in South Kingsville.

2. Ms Kati's medical history included asthma, hay fever, phobia about heights and partial loss of her right thumb. She was HIV Type 1 antibody positive. Her usual general practitioner was Dr Maryann Spottiswood at Westgarth Health[1].

3. On 7 September 2003, Ms Kati injured her chest and leg when she bumped into her flat mate in the hallway at home. On 10 September, Dr Spottiswood diagnosed possible fractured right ribs and urinary tract infection or haematouria arising from a bruised right kidney. She

[1] Also known as Kingsville Medical Centre

prescribed trimethoprim and Cephalexin. The trimethoprim was dispensed by Scowns Pharmacy in Kingsville on 10 September 2003.

4. On 16 September 2003, Ms Kati re-presented to Dr Simon Leslie at Westgarth Health. She told Dr Leslie that she did not have enough money for the Cephalexin prescribed by Dr Spottiswood. Dr Leslie confirmed the need to take the Cephalexin and provided a medical certificate to 22 September. On 16 September, Scowns Pharmacy dispensed the Cephalexin.

5. On 16 September 2003, Ms Kati also told Dr Leslie that she had only been working with her current employer for three months so she had no sick leave. In an application for Centrelink payments, Dr Leslie recorded that Ms Kati had difficulty using the steering wheel and was unable to rotate her right arm for tightening curtains on her truck.

6. On 22 September 2003, Dr Leslie noted that Ms Kati's arm injuries had almost resolved but the haematouria continued. On 30 September, he said she could return to work in two weeks.

7. Then, on 9 November 2003, Ms Kati presented to Dr Spottiswood with an infected right leg wound. She later reported to the hospital she had an accident at work and scraped her shin on a metal pole. Dr Spottiswood sutured the wound and prescribed more antibiotics. These were dispensed the same day by Scown's Pharmacy. They are not recorded as paid for under the Pharmaceutical Benefits Scheme. On 1 December, the leg wound was healing quite well.

8. On 17 December 2003, Ms Kati presented at the Emergency Department at Western Hospital with her, by now, ulcerated right leg and a deep laceration in right tibial region. The wound was sutured and she was discharged home with a medical certificate and return review appointments for 19 and 22 December 2003.

9. On 22 & 24 December 2003, Ms Kati re-presented at Western Hospital on crutches for review of her infected sutured right leg laceration. She was prescribed Panadiene forte and her medical certificate was extended. On 27 December, the sutures were removed and she was referred back to her general practitioner for further review. On 31 December, Dr Spottiswood recorded that Ms Kati's tibial wound was healing quite well. However, on 3 January 2004, she returned to Wester Hospital with continuing infection.

10. On 5 January 2004, Ms Kati consulted Dr Barry Hill at Westgarth Health Co-op. He changed her dressing and continued the antibiotic regime that the Western Hospital had implemented to treat her leg wound.

11. Ms Kati last consulted Dr Spottiswood on 10 January 2004. She complained about her infected skin wound and Dr Spottiswood prescribed more antibiotics. On that day, Dr Spottiswood also prescribed 120 tablets of bupropion hydrochloride which were dispensed by Scown's Pharmacy on the same day.[2]

12. On 13 January 2003, Scown's Pharmacy dispensed Cephalexin and Staphylex prescribed for Ms Kati by Dr Spottiswood and Dr Hill.

13. Although Cleanaway sent Ms Kati for a medical examination on 11 June 2004 and the form used to record the results of this examination is on Ms Kati's file, this form has not been filled in and there is no other record of this examination in evidence.

14. Accordingly, there is no evidence before me that Ms Kati had any other medical treatment after 10 January 2004.

15. Ms Kati was employed by M.A.D. Recruitment ("M.A.D.") to provide contract labour to Transpacific Cleanaway Pty Ltd ("Cleanaway").

16. Cleanaway provided drivers to collect, sort and recycle waste from households in the City of Stonnington under a contract between the City of Stonnington and Visy Paper Pty Ltd (trading as Visy Recycling) ("Visy") (the "contract").

17. Ms Kati worked as a waste collection driver/operator in the City of Stonnington. She drove a Volvo, purpose-built, dual control waste collection truck which was supplied new to Cleanaway by CMV Truck & Bus Pty Ltd ("Ms Kati's truck").

18. MacDonald Johnston Engineering had retrofitted a Mark IV side loader to the Volvo truck and they were responsible for providing on-going maintenance for the bin lifter.

19. Ms Kati's Cleanaway supervisor was Charles Fenech. In his statement prepared for the Court, Mr Fenech said that his staff start work at 5am and are usually at work by 4.45am. However, on 28 June 2004, Ms Kati was late for work. At 6.20am, she left the yard to begin her round.

[2] This is the only medication dispensed to Ms Kati under the Pharmaceutical Benefits Scheme after 20 November 2002.

20. At about 9.30am on 28 June 2004, Daniel Grimmer found Ms Kati unresponsive trapped between the telescopic arm of her waste collection truck and a wooden power pole outside 23 Closeburn Avenue in the City of Stonnington. She was unable to be revived.

21. The forensic pathologist who performed the autopsy formed the opinion that the cause of death was crush injury to the chest. He identified puncture wounds right anterior and posteriolateral chest, multiple right sided rib fractures, partial transaction mid right lower lobe of lung, right haemothorax, haemoperitoneum, lacerated left kidney, subcapsular haemorrhage superior aspect right lobe of liver, haemorrhage within superior pole of right thyroid gland and laryngeal petechiae. In his opinion the mechanism of death was most probably mechanical asphyxia and haemorrhage from the right lung.

22. Toxicological analysis detected delta-9-tetrahydrocannabinol at a concentration of 19ng/mL.

23. This Finding will review the circumstances of Ms Kati's death with particular emphasis on:

- Household recycling collection in the City of Stonnington;
- Equipment used for household recycling collection in the City of Stonnington

24. I will then comment and make recommendations intended to prevent other people dying for the reasons that Ms Kati died.

Household recycling collection in the City of Stonnington

25. The City of Stonnington provides household recycling collection services to all households in the municipality on a fortnightly basis. The City of Stonnington owns the 240 litre and 120 litre capacity recycle bins provided for household recycling. These recycle bins have a black body and a pale blue lid to differentiate them from other rubbish bins.

26. Since 2002, Visy had provided the City of Stonnington with services to collect, sort and recycle household materials in terms primarily determined by the City of Stonnington. On 3 May 2004, Visy commenced operation under a further five year contract which now required combined collection and sorting of recyclables in the City of Stonnington (the "contract").

27. The key activities to be performed by Visy under the contract included collection of recyclables from residential and commercial properties within the municipality each week on

the same day as garbage collection and transportation of collected recyclables to a sorting facility.

28. Under the contract, Visy was also responsible for legislative compliance and contractor occupational health and safety. In particular, Clause 6.4 of the contract imposed an obligation on Visy to ensure that no employee agent or sub-contractor is under the influence of any drug which could impede his or her ability to safely and efficiently perform the Recyclables Collection Service.

29. Visy does not specialise in roadside collections. However, the contract acknowledged Visy's intention to sub-contract the collection of recyclables to Cleanaway Global Waste Management ("Cleanaway"). This partnership between Visy and Cleanaway was important to the City of Stonnington in selecting Visy as the preferred tenderer.

30. The City of Stonnington Manager Physical Works & Services, was responsible for day-to-day supervision of their contract with Visy. His role included auditing performance of the contract, monitoring and reviewing all requests received by the Council in relation to the contract and facilitating and chairing monthly contract meetings. He also had oversight of surveillance of the crews undertaking their work in the field and concerns were discussed at the monthly meetings.

31. Visy and Cleanaway were also required to provide the City of Stonnington with an annual Contract Management Plan for the collection of recyclables which included occupational health and safety plans.

32. On 9 June 2004, this monitoring process reported that the list of outstanding items was already too large to manage and requests had been outstanding for too long. Problems raised by the City of Stonnington included reversing a Cleanaway vehicle the length of Kensington Road and effecting side arm collections at the same time. They also recorded that the initial honeymoon period was coming to an end. None of these complaints specifically referred to Ms Kati.

33. Therefore, I have formed the view that the City of Stonnington had put in place the processes required to monitor execution of their contract with Visy.

34. This process had identified teething problems with implementation of the Visy contract. However, the short time between when this contract commenced and when Ms Kati died did not allow time for the City of Stonnington to usefully identify any of the issues that specifically related to her death.

M.A.D. Recruitment ("M.A.D.")

35. The contract between Visy and the City of Stonnington noted that Cleanaway waste management drivers were employed directly or through Visy's designated labour hire company. M.A.D. was their designated labour hire company.

36. In their documentation, M.A.D. said:

"We believe that the extra effort and attention to detail afforded to OH&S prior to placement of our employees reduces the risk of injury."

and

"All M.A.D. Recruitment casuals undergo an initial induction into OH&S policies and procedures. Coupled with the internal induction, all casuals to be placed for work at your company will undergo a site-specific induction and site tour, ensuring that all site and job specific demands of OH&S are covered."

37. On 10 February 2004, Charles Fenech from Cleanaway Municipal Stonnington contacted M.A.D. seeking a driver for 28 days starting on 1 June 2004. The referral was taken by Adam Wilcox. I have assumed this is the person designated "AW" in other documentation.

38. Mr Wilcox was Director of M.A.D. Recruitment. He remained the main M.A.D. consultant responsible for their labour contract with Cleanaway.

39. On 10 March and 1 April 2004, Mr Wilcox reviewed the Brooklyn worksite at Cleanaway Stonnington. In his review of equipment, Mr Wilcox noted that the vehicles for the contract were new vehicles and designated their cleaning, maintenance, guarding and stop/start buttons as not applicable ("n/a").[3]

[3] Earlier similar documentation is specific in defining this meaning of "n/a".

40. On 30 June 2004, after Ms Kati died, Mr Wilcox returned to review the Brooklyn worksite at Cleanaway Stonnington. He continued to record cleaning, maintenance, guarding and stop/start buttons on machinery vehicle and warehousing as not "n/a".

41. Therefore, I have formed the view that Mr Wilcox did not consider that safety protection on trucks used by M.A.D. employees was within his occupational health and safety responsibility.

42. On 28 May 2004, Ms Kati applied for a position at M.A.D. Recruitment.

43. Ms Kati held a Victorian heavy rigid drivers licence current to 6 April 2011. In her *curriculum vitae*, she also said she had about 18 months experience in 2002-3 driving a truck equipped with a waste bin collection arm for Waste Works. In 2003, she had also worked for seven months delivering packages and pallets for Doug Hayes Transport. Ms Kati also had experience in hospitality and security industries in New Zealand.

44. Ms Kati also completed an M.A.D. Health and Safety Declaration in which she acknowledged on-going asthma but said it did not interfere with her work. She denied taking drugs or medication that may effect her in the workplace.

45. On 28 May 2004, Mr Wilcox interviewed Ms Kati for the position of truck driver in the waste industry. Mr Wilcox noted that Ms Kati was very pleasant, will do any work and had 18 months experience solo at Waste Works.

46. A referee check with Waste Works confirmed Ms Kati had been employed as a truck operator and picking up wheelie bins. Waste Works also told M.A.D.:

> *"Lovely girl. Well liked by employers and co-workers, nice friendly attitude...*
>
> *Very punctual...*
>
> *Happy go lucky friendly personality always smiling and generally in a positive mood."*

47. The M.A.D. referee check with Doug Hayes Transport also confirmed Ms Kati was a:

> *"Good honest worker, always willing to help others, reliable and well respected...*
>
> *Nice lady, quiet sort of person, didn't hear much from her just went ahead and did her work...*

Always on time for work never late"

48. In a statement prepared for the Coroner, Julie Hayes from Doug Hayes Transport confirmed that Ms Kati was very efficient and conscientious. Ms Kati told Ms Hayes she left their employment because her flatmate needed a driver. The flatmate was Shane MacLennan from Shane's Painting & Decorating. Ms Hayes never saw any indicators that caused concern or raised her suspicion that Ms Kati used alcohol or drugs.

49. On 28 May 2004, Ms Kati underwent induction administered by M.A.D.. The documents she was required to read included:

> *No M.A.D. Recruitment employees shall consume, or be under the influence of drugs and/or alcohol whilst on site, regardless of the policies of the host employer....*
>
> *Any individual under the influence of drugs or alcohol at work will be asked to leave the site immediately. M.A.D. Recruitment may choose to conduct interviews to investigate the issue further, and the employee may be subjected to counselling referral, disciple, termination and/or police intervention."*

50. Further, the pre start checklist included the requirement:

> *"to NEVER operate a vehicle under the influence of alcohol and drugs."*

51. On 31 May 2004, Mr Wilcox referred Ms Kati for the position with Cleanaway Stonnington. Ms Kati was offered and accepted the position. She told Mr Wilcox that she was very excited.

52. On 1 June 2004, M.A.D. placed Ms Kati with Cleanaway at Stonnington for one month with the opportunity for permanent appointment later.

53. M.A.D. paid Ms Kati for 11.78 hours work to 28 May 2004 and then four full weeks commencing 29 May to 25 June 2004.

Visy Recycling

54. Visy subcontracted Cleanaway to collect household recyclable material and deliver it to the Visy recycling facility in Springvale.

55. Visy provides Kerbside Collections Procedure Guidelines for contractors. Visy also requires each contracting company to develop their own Safety Policy. These provisions include:

- All accidents/incidents and near misses which involve a vehicle or a person must be reported immediately.
- All staff must be trained in the safe performance of their job and records kept regarding training attended.
- An induction checklist must be used for the purpose of training new employees.
- Periodic checks on the progress and problems of new starters.

56. Accordingly, Visy established a Safety Plan for their contract with Stonnington City Council. In particular, this Safety Plan required all their own employees, sub-contractors, casual employees and visitors to comply with the Safety Plan established for the duration of the contract. This Safety Plan imposed responsibility on each employee to protect their own safety and undertake a compulsory Visy induction.

Cleanaway Global Waste Management ("Cleanaway")

57. Cleanaway Global Waste Management was an operating division of Brambles Australia Ltd. In 2007, Transpacific Cleanaway took over Cleanaway.

58. The Visy contract with Cleanaway required all accidents/incidents and near misses which involved a vehicle or a person to be reported immediately. Visy have said that there have been no near misses involving collection arms reported to Visy Recycling under their Kerbside Collections Procedure Guidelines since 2000.

59. Cleanaway employed a supervisor, a leading hand and four other permanent waste collection driver/operators to operate the five collection vehicles required to perform the work required under the contract between Visy and the City of Stonnington.

60. Relief drivers were employed using M.A.D. agency personnel on an 'as needs' basis. However, Cleanaway was required to provide driver training and assess relief drivers as competent before they undertook driving duties.

61. Vehicle operators were required to perform daily collections, notify the supervisor or leading hand of rejected collections, complete a daily report, ensure they complied with the road and safety regulations and that they operated in a safe manner and did not put themselves, their peers or the public at risk.

62. Charles Fenech was the supervisor employed by Cleanaway to manage their operations at the City of Stonnington. He had been employed by Cleanaway as an operations supervisor for about 14 years.

63. Mr Fenech was responsible for Ms Kati's induction, supervision and distribution of work among the five waste collection driver/operators. In his statement he said:

> *"From the day she was employed she was happy excellent employee and she was very competent in her work. She did not have any incidents or problems".*

64. Cleanaway also provided Ms Kati with a position description which included information about General Requirements and Vehicle Operation requirements. These included:

- General requirements

> *"Operating a Solo Dual Control Waste Collection Vehicle requires well developed skills and constant alertness in order not to cause injury or property damage. If you are unwell are taking any substance that may affect your safe work performance you must not operate a Solo Dual Control Waste Collection Vehicle. You must inform your supervisor of any such situation."*

- Vehicle Operation Requirements

> *"Ensure vehicle is stationary when operating lifting devices to service mobile garbage bins and proceed forward if safe to do so."*

65. Cleanaway National Drivers' Operating and Procedures Manual Section 3 Company Rules dated 29/01/02 provided the General Rules and Safety Rules that applied to new employees and contractors:

- Cleanaway Service Rules 3.2.9 stated:

> *"Machinery, equipment, vehicles, etc, are only to be operated by those persons who have been trained and hold the required permits or certificates of competence or the means of authorisation. This especially applies to powered machinery and other equipment known to be hazardous...."*

- Cleanaway General Rules 3.2.2(a) stated:

" Report to work at the required time and where required, clock on."

- Cleanaway Service Rules 3.2.5(b) stated:

  "On completion of training in a service system and given a period of time to gain experience in that system, drivers are required to be able to achieve the service standard and productivity of that system."

- Cleanaway Service Rules 3.2.5(c) stated:

  "Service all customers as per the run sheet..."

- Cleanaway Safety Rules 3.3 Rule 6 also stated:

  "It is expressly forbidden for any person to bring illegal drugs into the Cleanaway premises. It is also forbidden to use illegal drugs whilst at work.....

  ALL PERSONS ARE ADVISED THAT IT IS THE POLICY OF CLEANAWAY TO REPORT ANY POSSESSION OR USE OF ILLEGAL DRUGS TO THE POLICE AND FURTHER DISCIPLINARY ACTION MAY FOLLOW."

66. On 1 June 2004[4], Mr Fenech referred Ms Kati to John Reid for assessment.

67. Mr Reid was employed by Cleanaway to assess drivers' capacity to perform the work. As training for this assessment task, Mr Reid completed a 10 day Train the Trainer Course at DECA Training. Further, on 30 March 2004, Mr Reid was trained by MacDonald Johnston Engineering in the use of the Mark IV side loader bin lifter. Mr Reid no longer works for Cleanaway.

68. On 2 June 2004, Mr Reid assessed Ms Kati for the Stonnington Recycle contract. This assessment took over four hours and included a driving test.

69. Mr Reid used a Cleanaway evaluation report form to evaluate Ms Kati as satisfactory to perform the work required by the City of Stonnington Recycle contract. This form does not include assessment of her use of the collection arm. However, his statement indicates she activated the hydraulics and picked up recycle bins as part of her assessment.

[4] Mr Fenech's statement says he inducted Ms Kati on 31/7/04. However, I presume this is a mistake.

70. In particular, Mr Reid commented:

> *"Gaylee comes to Cleanaway as an experienced driver/operator and after spending time with Gaylee, feel she should be able to complete her duties without any problems. Very good!"*

71. Ms Kati countersigned this document.

72. On 3 June 2004, Mr Fenech sent Ms Kati out with one of the other drivers for a week to observe the job as part of her induction.

73. Then, on 11 June 2004, Ms Kati also agreed to abide by the requirements of the position description for a Solo (Dual Control) Waste Truck Driver at Cleanaway Melbourne Municipal and she was referred for a medical examination.

74. On 11 June 2004, Ms Kati also completed a Cleanaway Bayswater Drivers' Application for Employment. Her assessment indicated that she had a great capacity for sincerity to family and close co-workers, she had strong personal attachments and she did not mind the routine of driving. Ms Kati was also assessed as "generally avoiding risks with her truck" and "using managers and dispatchers as valuable resources because they know what works".

75. On 11 June 2004, Ms Kati was also assessed using a Cleanaway Driver Analysis Answer Sheet in which she indicated she had two prior work-related injuries. One involved '*fell through a hole in back of truck scaping shin.*" The other involved partial loss of her right thumb in 1978.

76. However, in reviewing Ms Kati's previous employment experience, Kellers Recruiting & Retention Success System Driver Analysis for Cleanaway Brooklyn terminal indicated that she had two accidents in 2003. One involved a front right hand turn when she clipped the trailer. The other involved a side arm at full extension damaging the rear of a car.

77. Although one report relates to injuries and the other report relates to incidents, the two reports are inconsistent. Therefore, I am not confident that Ms Kati accurately reported her previous work-related injuries to Cleanaway.

78. Further, M.A.D. records show that Ms Kati rang Mr Wilcox (AW) at 5.00am on 18 June 2004 to say she was running late for work and that Mr Wilcox contacted Mr Fenech.

79. However, Ms Kati's Municipal Daily Drivers Report records that she started work at 5.00am on 18 June as usual. She also recorded that she picked up her first bin at 5.30am that day as usual. Ms Kati only took one load to the tip site that day and only lifted 360 bins which is the equivalent of one load rather than the two, three or even four loads she usually collected.

80. Therefore, although Ms Kati only took one load to the tip site and only lifted 360 bins on 18 June 2004, the times she recorded are inconsistent with her arriving late for work that day.

81. Further, there is no indication in the Cleanaway records to suggest that Mr Fenech noted Ms Kati's late arrival on 18 June 2004. On 21 June 2004, M.A.D. also contacted Cleanaway about the Stonnington contract. Cleanaway said Ms Kati was going very well with no problems.

82. Therefore, I am not confident that Ms Kati's Municipal Daily Drivers Report records and Mr Fenech's records and assessments of her work accurately reported her work history in the four weeks she was collecting recyclables in the City of Stonnington In June 2004.

83. On 21 June 2004, Ms Kati also signed the Brambles Code of Conduct Policy. On 25 June, she was provided with a Drivers Report by Cleanaway Bayswater. This assessment included her positive and negative traits assessed as a result of the Driver Analysis she had taken. This report included the following statements:

> *"Gaylee generally avoids taking risks with her truck."*
>
> *"Focussing on the actions required to drive safely."*
>
> *"Being conscious of safety and avoiding risks." And*
>
> *"Being under control, even in dangerous situations."*

84. Ms Kati's Driver Analysis also included the following possible safety concerns:

> *"Seeing some safety regulations as superficial."*
>
> *"Forgetting to take care of truck maintenance if focussing on something else."*
>
> *"Accepting unsafe or broken equipment instead of voicing concerns."*
>
> *"Projects the appearance of not caring about performance."*

85. According to a document dated 31 June 2004 which was provided to WorkSafe, Ms Kati was further assessed by Cleanaway using the Melbourne Municipal Employee Induction Checklist. Ms Kati and Mr Fenech also signed the declaration on this document confirming that she agreed to comply with OH&S legislation, Company policies, rules, procedures and safe operating instructions.

86. Mr Fenech says he then completed her induction. However, the date on this document also raises doubts about its accuracy.

Equipment used for household recycling collection in the City of Stonnington

87. On 28 June 2004, Ms Kati was driving a purpose-modified recycling collection truck fitted with dual controls so that it could be driven from the right or left seat. There was also an automatic transmission gear selector and park brake lever in the centre console of the cabin.

88. Ms Kati's truck was registered to Brambles Australia Ltd Cleanaway in Bayswater as a blue 2003 Volvo FL garbage collection unit registered number STI 982 ("Ms Kati's truck").[5]

89. Ms Kati's truck was fitted with a MacDonald Johnston Mark IV side loader unit on the left hand side. It was subject to a Heavy Vehicle Modification Plate Approval certificate No. 10170753.

90. MacDonald Johnston Engineering Pty Ltd ("MacDonald Johnston") performed the modifications. They design manufacture market and service a wide range of refuse and sweeping equipment including manufacturing and installing garbage handling equipment on to cab chassis assemblies. MacDonald Johnston carry out all their modifications under the national code of Practice for Heavy Vehicle Modifications (Vehicle Standards Bulletin 6) to ensure they continue to comply with the Australian Design Rules.

91. David Waldron was the general manager of MacDonald Johnston Engineering Pty Ltd. According to Mr Waldron, the Mark IV side loader was considered a reliable refuse collection vehicle and they manufactured over 900 units before it was replaced by the Gen V side loader.

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[5] Transpacific Cleanaway notified CMV Truck & Bus Pty Ltd of the coronial investigation and their right to make an application to be an interested party. However, the Court did not receive any application from CMV Truck & Bus Pty Ltd

92. The Mark IV side loader bin lifter was designed to be operated from either inside the cabin using a control in the centre console between the seats or from outside using a remote joystick and safety switch located within the left hand door well whilst standing by the left hand cabin door.

93. When in operation, the slide arm of the Mark IV side loader bin lifter extended hydraulically to 1800mm from the truck chassis. The bin lifter module acted as a carrier for the bin pick up head at the end of the slide arm. These components extended the reach of the mechanism to 2400 to 2600mm from the vehicle.

94. When in operation, the waste collection driver/operator used a joystick type control handle to manipulate the bin pick up head to pick up the bin. The slide arm retracted and rotated the bin through an arc in order to load the contents of the bin into the hopper on the truck.

95. In order to operate the Mark IV side loader bin lifter, the waste collection driver/operator advanced the truck's engine to 900rpm. The engine speed then allowed the truck's hydraulics to operate the side loader.

96. This procedure isolated the normal engine accelerator until the slide arm and bin lifter had retracted to their stowed position. Therefore, the truck could not accelerate while the controls on the side bin lifter were operating. However, it could proceed when the automatic gear was selected to "Drive".

97. The Declaration of Conformity signed by Mr Waldron and the Chief Engineer of MacDonald Johnston in February 2008 certified that, at that time, the side loader conformed with the standards imposed by the Occupational Health and Safety Commonwealth Act 1991 and the State Occupational Health and Safety Acts and associated regulations.[6]

98. The Declaration of Conformity indicated the inside controls for the slide arm and bin lifter on the side loader bin lifter that only operate when the control was activated and ceased to move when the control was released ("hold-to-run" controls). There was no automatic movement. There were mirrors which must be correctly adjusted and there was a camera in the cabin to allow the driver to monitor the bins during lifting using the internal controls.

[6] This document is labelled: "*This document is not to be used in any way detrimental to the interests of MacDonald Johnston Pty Ltd.*"

99. Therefore, the side loader bin lifter mechanism was under the waste collection driver/operator's full control when it was operated from within the cabin.

100. The Declaration of Conformity also said that the external controls for the slide arm and bin lifter on the side loader bin lifter had been placed deliberately inside the cab to ensure the operator was always clear. They were also fitted with indicator lights on the control panel which were activated when any parts were moving.

101. The Declaration of Conformity further indicated that operating the external control with the vehicle moving was a known hazard. The safeguard designed into the system included a requirement for the controls in the cabin to be selected to "external" mode by the operator. When the "external" mode was selected the controls would not operate unless the vehicle is in neutral.

102. We know that, on 28 June 2004 after Ms Kati died, Ms Kati's truck was found with the "drive" gear selected. Therefore, if the controls were working properly, the external control would have been disabled. Further, the external control mechanism operated the bin lifter module but did not operate the side arm mechanism on the side loader bin lifter.

103. Therefore, Ms Kati should not have been able to activate the side arm mechanism from outside the truck because it was in "drive" gear.

104. I note that MacDonald Johnston have also deduced that Ms Kati must have extended the slide arm using the internal control mechanism before she exited the truck on 28 June 2004. They base this opinion on the properly working control for the bin lifter equipment. In particular, the external controls should not have operated if the truck was in "drive" gear and the external control mechanism operated the bin lifter module but did not operate the side arm mechanism on the side loader bin lifter.

105. Ms Kati's truck was subject of a Cleanaway Stonnington Service Maintenance Contract with MacDonald Johnston Engineering Company Pty Ltd. It was last serviced on 11 June 2004.

106. The records from this Cleanaway Stonnington Service Maintenance Contract and waste collection driver/operators' independent notifications of equipment failures to Cleanaway include the following malfunctions:

- On 16 April 2004, MacDonald Johnston issued an invoice:

"Auto retracting when stationary and no auto rev's. Checked speed control relay. Repaired bad connection from control box to under dash."

- On 5 May 2004, MacDonald Johnston issued an invoice:

  "Slide (side) auto retracting at all times. Arrived on site to find faulty speed control relay. Removed program and fitted new relay to find okay."

- On 14 May 2004, MacDonald Johnston issued an invoice:

  "Unable to use exterior joy stick. Arrived at site to check and found faulty speed control relay. Replaced as required."

- On 5 May 2004, the speed control relay was repaired:

  "Side auto retracting at all times."

- On 12 May 2004, the hopper camera and in cab monitor had fallen off.

- On 14 May 2004, MacDonald Johnston issued an invoice:

  "Unable to use exterior joy stick

  Arrived on site to check and found faulty speed control relay."

- On 16 May 2004, the speed control relay was repaired for:

  "auto retracting when stationary and no auto rev."

- At 8.00am on 9 June 2004, Ms Kati reported waiting for a mechanic to fix the external joy stick.

- At 8.25am on 25 June 2004, Ms Kati reported a further arm malfunction on her truck. The 25 June was the last time Ms Kati's truck was used before the day she died.

107. On 1 July 2004, MacDonald Johnston issued 14 tax invoices for work undertaken on Ms Kati's truck in June under the maintenance contract. These invoices do not include work performed on 25 June.

108. On 14 July 2004, MacDonald Johnston issued a further tax invoice under the maintenance contract for Ms Kati's truck:

> *"No throttle advance at times and delay on lifter*
>
> *Arrived on site & check – unable to fault*
>
> *Tried several tests. Removed transistor from comb board on output side of PLC 3 & fitted wires directly to PLC."*

109. In their submissions, MacDonald Johnston attribute this tax invoice to the work performed on 25 June 2004. MacDonald Johnston also say that the "no throttle advance" denoted a situation where the sidearm was extending and retracting at a slower speed than usual.

110. Further, I note that the problems reported on 16 April and 12 May 2004 were software problems associated with the speed relay. The mechanical arm was functioning in a manner that prevented it being lowered from the park position even when the vehicle was stationary or travelling at less than 4kph. Mr Waldron says that this problem was fixed.

111. The tax invoices produced by MacDonald Johnston and the waste collection driver/operator reports indicate that Ms Kati and other waste collection driver/operators routinely used the external joystick on Ms Kati's truck to operate the bin lifter.

112. Further, these tax invoices indicate to me that the bin lifter on Ms Kati's truck was subject to reports of on–going problems in relation to the speed control relay. In that sense, the bin lifter technology was either unreliable or, alternatively, Ms Kati believed it was unreliable.

113. As well, the report dated 14 July 2004, indicates that the wiring of the transistor controlling the side arm was changed on 25 June 2004. There is no further evidence as to whether this changed the operation of the side arm or Ms Kati's perception of its reliability.

114. On 30 March 2004, MacDonald Johnston provided Simon Grey and John Reid from Cleanaway with training in the use of the Mark IV side loader bin lifter. This training adopted the MK 4 Side Loader Compactor Operator Training Checklist (the "checklist") attached to the MacDonald Johnston submission.

115. Operating techniques included in the checklist included bin approach emptying and put down and correct attitude to joystick use. The Certificate of Completion of the Trainee Operator Training Check List also included ability to recognise and report faults.

116. Several operator/drivers provided statements to Work Safe Victoria describing their training in operation of the Mark IV side loader bin lifter. Mr Fenech said the correct operation when a bin was inaccessible was to stop the truck, apply the park brake and put it into neutral, get out of the truck, move the bin to a clear position, get back into the truck and empty the bin. Other operators, Alice Murphy and Damir Ukalovic, also said they used this procedure to access inaccessible bins.

117. However, Tomaslav Tukalovic stated that he used the outside joystick to empty an obstructed bin. He said he was told in driver training to do it that way.

118. Therefore, I am unable to say whether the bin lifter training delivered to Ms Kati favoured use of the inside joystick or whether the training delivered to Ms Kati recommended use of the remote joystick to lift inaccessible bins.

119. Photograph No. 25 in the WorkSafe Victoria brief shows the in-cabin control box. In this photograph, the bin lift selector switch on the in-cabin control box was hidden by clothing. Therefore, it seems that no one checked and there is no direct evidence before me as to the status of the bin lift selector switch when Ms Kati was found on 28 June 2004. Further, there seems to be no record of the status of the external control light indicator in Ms Kati's truck when she was found.

120. This evidence would have further assisted WorkSafe and MacDonald Johnston and me in determining whether the external control mechanism was operating properly and that it did not influence Ms Kati's death.

121. I also note that Senior Constable Simon Borg was not asked to and did not check the operation of the lifting arm. Therefore, there is no direct evidence before me as to whether the MacDonald Johnston Mark IV side loader bin lifter on Ms Kati's truck was operating properly on 28 June 2004.

122. Accordingly, I remain reluctant to accept that Ms Kati used the internal control mechanism to extend the slider arm of the bin lifter before she left the cabin of her truck or to reject any possibility that the external control mechanism influenced her death.

123. The slide arm and bin lifter of the MacDonald Johnston Mark IV side loader bin lifter have been designed to retract automatically when the truck speed reaches 3-4kph. The driver operator can override this auto-park function up to the speed of 12kph.

124. MacDonald Johnston checked Ms Kati's vehicle and found that the slide arm and bin lifter retracted normally when the truck speed reached 4kph.

125. Further, the Declaration of Conformity indicates there are emergency stop buttons located at each control station. That is, they are inside the cabin. However, I could find no evidence that there was an emergency stop mechanism for the side loader arm on the outside of the vehicle.

126. Despite the reported failure in the speed control relay on Ms Kati's truck, the Declaration of Conformity does not adduce any potential hazards associated with errors in software.

127. The park brake on Ms Kati's truck was not influenced by modifications to import the MacDonald Johnston Mark IV side loader bin lifter. Therefore, the controls and safety issues relating to the park brake remain those implemented by the truck manufacturer, Volvo.

128. I note that John Lambert was an independent expert witness retained by WorkSafe to provide a report in relation to its investigation of Ms Kati's death. As part of his investigation, Mr Lambert inspected the operation of a 'near identical' Volvo vehicle. This truck was fitted with a side loader bin lifter. However, it did not have an external control hydraulic arm joystick on the left hand side of the left hand seat.

129. Mr Lambert did not consider the risks associated with the side arm of Ms Kati's truck except to identify them as possible "plant" for the purposes of Regulation 106 of the Occupational Health and Safety (Plant) Regulations 1995 and recommend a thorough risk assessment. He also said that, if it applied at all, this definition of plant only applied if the side arm is being operated from the external controls.

130. Rather, in Mr Lambert's opinion, the principal contributing factors to the fatality included:

- *"The fact that the parking brake control design was such that it was spring loaded to come off"* and

- *"The fact that it was possible for the locking collar on the park brake to just catch and be held in place by friction and for vibration or other movement to cause the collar to disengage"* and

- *"The fact that the vehicle was on a down slope that was great enough to cause it to move off once the park brake disengaged."*

131. Mr Lambert based this opinion on Ms Kati's reputation as a skilled and highly productive driver. He assumed that someone known to be skilled and highly productive would have attempted to maximise their productivity when they had been late for work and their colleagues had been allocated to compensate for this:

> *"Hence there is a possibility that the driver had been pushing the brake control to the right as she was commencing to exit the door to the left and in doing so did not push the park brake lever all the way over."*

132. However, Ms Kati had only worked using their Cleanaway equipment for four weeks. As discussed above, in Mr Fenech's opinion she was a happy excellent employee and she was very competent in her work. The evidence is that she was not always reliable in her work including being late on the day she died. When he assessed the scene, Mr Lambert did not know about her cannabis use. There is no evidence before me to indicate that she would have attempted to maximise her productivity in the circumstances of the day and, in the absence of this information, it is a long jump to conclude that that occurred.

133. Rather, Ms Kati failed to disengage the 'drive' gear on her truck before she vacated the cabin. In my opinion, this failure reduces the likelihood that she went through the routine movement of disengaging the automatic gears and activating the hand brake.

134. As well, Ms Kati's truck was a standard Volvo FL chassis. Volvo states that the hand brake also operates as a safety brake that may be used if a fault occurs in the ordinary brakes. In position 1, the parking brake is fully applied to the tractor unit and the service brake is applied to the trailer. When the parking brake is in position 2, the brakes on the trailer are released.

135. Therefore, I find it most unlikely that this failure in the park brake system has not occurred in any other Volvo trucks. There is no evidence before me that this has occurred.

136. Mr Borg also checked the parking brake system on Ms Kati's truck at the scene. He found no fault with the park brake system which may have caused or contributed to the collision.

137. Mr Borg found that Ms Kati's truck did not move backwards or forwards when the truck was in 'drive' and the park brake was on unless the throttle was completely depressed. At full throttle it crept forward very slightly and slowly. Accordingly, Mr Borg classed the brake holding ability as excellent.

138. On the other hand, with the park brake off and the 'drive' gear was engaged, Mr Borg found that the vehicle moved immediately and an application of the brake pedal was required to hold it stationary. When the park brake was released, there was a delay of about three seconds before the vehicle began to move forward.

139. Mr Borg did not comment on the possibility that Ms Kati activated the park brake before she left the cabin but that it slipped out of operation because she did not push the lever as far as required to lock it.

140. Therefore, I have formed the view that it is unlikely that the park brake system on Ms Kati's truck failed and that this contributed to Ms Kati's death.

The Incident

141. There is no evidence before me about Ms Kati's living arrangements or her behaviour over the weekend of the 25-28 June 2004.

142. On Monday 28 June 2004, Ms Kati was late for work. At about 5.10am, a colleague tried to ring her but her phone was engaged. At about 5.30am, Mr Fenech rang Ms Kati. She apologised and said she had slept in. Ms Kati told Mr Fenech that, rather than riding her bike as usual, she would get a cab to work.

143. Mr Fenech despatched the other drivers and asked them to include the margins of Ms Kati's round to minimise the effect of her late start. He then waited for her arrival.

144. At 5.50am on 28 June 2004, Ms Kati arrived for work in a taxi and clocked in. Mr Fenech told her not to hurry and to have a cup of coffee before she started work. He spoke to her while she had her coffee and a smoke. She did not seem drug-affected or otherwise unusual.

145. Mr Fenech also said:

"I have never been very familiar with drugs of any description. To my knowledge I have never seen anyone affected by drugs and because of this I wouldn't know if now I did see some one drug affected."

146. However, in the close confines of their coffee and chat, I am of the view that even Mr Fenech would have noticed a cannabis-like smell if it was burning as part of her cigarette.

147. The Municipal Daily Drivers report completed by Ms Kati on 28 June 2004 indicated that she was driving her usual truck, STI982.[7] She started work at 6.15am, the hour meter start was 481.5 hours, and the odometer was 7335km.

148. Mr Fenech said he last saw her at 6.20am on 28 June 2004 when he left the yard and she followed him out.

149. There is no evidence before me that anyone saw Ms Kati or her truck or had any contact with her until about 9.30am on 28 June 2004.

150. However, evidence at the scene where Ms Kati died suggests that she had been driving the truck from the left hand seat because:

- The camera monitor was directed towards the left hand side of the cabin.
- Her route map was on dashboard in front of the left hand seat.
- The driver's door on the left hand side was open.
- The telescopic arm for collecting waste bins was fitted to the left hand side of the truck.

151. Further, it seems Ms Kati did not take a load to the tip site before she died because:

[7] Ms Kati had driven the same vehicle on 1, 2, 3, 4, 7, 8, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25 June 2004.

- She has not completed any of the load details on the Municipal Daily Drivers report for 28 June 2004 except to write that she was intending to access the tip site at Visy Laverton.

- There are no Scan Card dockets provided to me for 28 June 2004.

- On other days, Ms Kati commenced earlier and took her first load to the tip site at between 7.45am and 9.30am. However, she did not usually return for her next run until after 10.00am.

152. I note that Mr Borg recorded the odometer reading on Ms Kati's truck was 7238km at the scene of her death. Using the most direct route, 26 Closeburn Avenue in Prahran is 4.8 km from the Stonnington Waste Transfer Station at 32 Weir Street Malvern. Therefore, I cannot explain as a transcription error the inconsistency between Mr Borg's reading and Ms Kati's recording of 7335km at the end of the shift on 25 June and at the beginning of her shift on 28 June 2004.

153. Accordingly, other than from the depot to Closeburn Avenue, I am unable to say where or how far Ms Kati drove her truck on 28 June 2004.

154. At about 9.30am on 28 June 2004, the occupant of 23 Closeburn Avenue, Fae Campbell, thought she heard a crash outside her house. There is no record that Ms Campbell took any action in relation to this sound although WorkSafe Victoria believe that the power pole in the street had been hit with sufficient force to pull off the facia boards which attached the power lines to the house.

155. Daniel Grimmer worked for the City of Stonnington as a street sweeper. At 9.35am on 28 June 2004, Mr Grimmer was driving his street sweeper in Closeburn Avenue when his progress was stopped by Ms Kati's truck stationary on the side of the road. The orange flashing lights on the truck were operating. After waiting for several minutes for the truck to move, Mr Grimmer went to investigate.

156. Mr Grimmer found Ms Kati unresponsive crushed between the collection arm of the truck and a wooden power pole outside 23 Closeburn Avenue. She was face forward to the pole and the boom had struck her at the base of her back. Ms Kati had already died.

157. From Mr Grimmer's perspective, Ms Kati looked as if she had tried to move the bin from behind the power pole. If I rely on Ms Campbell's observation, I estimate Ms Kati had been in this position for between five and eight minutes when Mr Grimmer found her.

158. Two other bins had been knocked over about six metres from where Ms Kati was trapped. They looked as if they had been also knocked over by the collection arm. These bins could account for the noise Ms Campbell heard at 9.30am. This possibility would reduce the time Ms Kati was *in situ* before Ms Grimmer found her.

159. Further, there is no evidence before me about the position of the bin outside 23 Closeburn Avenue before Ms Kati arrived. There is also no evidence as to whether the bin had been emptied.

160. Therefore, I cannot say when Ms Kati left her vehicle or whether she left her vehicle to move the bin outside 23 Closeburn Avenue or whether her death related to some other reason for her leaving her cabin.

161. When Mr Grimmer realised someone had been injured, he contacted Trevor Jones using his two-way radio. Mr Grimmer's supervisor, Michael Varga, heard the conversation and drove to the site.

162. When he arrived at the scene, Mr Varga found Ms Kati pinned against a power pole by the slider arm on the side of her truck. The engine of the truck was still running with the gears still engaged and the handbrake was off. The driver's door on the left hand side was open.

163. The front left wheel on Ms Kati's truck had mounted the kerb and sunk into the grass on the nature strip. The centre and right front bumper of the truck had collided with the rear of a parked car in the street.

164. The wheels of the garbage bin had travelled about 10cm sideways in the same direction as the truck was facing and dug into the nature strip. This does not seem far enough to dislodge the power lines from the fascia board of the Ms Campbell's house.

165. At the request of ambulance officers, Mr Varga reversed the truck about 18 inches to release Ms Kati. He then put the gears into neutral, put the hand brake on and shut the motor off. This was the status of Ms Kati's truck when investigators arrived.

166. The forensic pathologist who performed the autopsy formed the opinion that the cause of death was crush injury to the chest. In his opinion, the mechanism of death was most probably mechanical asphyxia and haemorrhage from the right lung.

167. Further, Ms Kati's injuries were consistent with her being pinned against a power pole by the slide arm on her truck.

168. Toxicological analysis detected delta-9-tetrahydrocannabinol at 19ng/mL.

169. Dr Morris Odell says that it is certain that a person with this level of delta-9-tetrahydrocannabinol would still be affected by the recent consumption of the drug. Further, delta-9-tetrahydrocannabinol levels over 4-5ng/ml are evidence of cannabis consumption in the two to three hours before death. In his opinion she died perhaps 1-2 hours after having used cannabis, that is sometime after about 7.30am.

170. Therefore, although no one found any drug paraphernalia in the truck or Ms Kati's backpack, I have formed the opinion that Ms Kati used cannabis after she left the yard and before she died. Given she was a smoker, I am also of the view that she probably smoked the cannabis as a cigarette.

COMMENTS

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

1. Gaylee Kati died on 28 June 2004 when she was working as a driver/operator collecting recyclable household waste in the City of Stonnington.

2. Ms Kati was employed by M.A.D. Recruitment ("M.A.D.") to provide contract labour to Transpacific Cleanaway Pty Ltd ("Cleanaway"). Cleanaway provided drivers for the City of Stonnington under a contract between the City of Stonnington and Visy Paper Pty Ltd (trading as Visy Recycling) ("Visy") to collect, sort and recycle waste from households in the municipality.

3. In May 2004, Visy entered a new contract with the City of Stonnington to provide waste collection services. This new contract required Visy and, through the sub-contract, Cleanaway to replace their previous manual recyclable waste collection procedures with mechanical collection and emptying procedures for specially designed so-called "wheelie bins".

4. As part of the work required to fulfil the new contract, Ms Kati drove a 2003 Volvo HL, purpose-built, dual control waste collection truck fitted with a MacDonald Johnston Mark IV side loader unit on the left hand side ("Ms Kati's truck"). [8] This truck was supplied new to Cleanaway by CMV Truck & Bus Pty Ltd.

5. Ms Kati's truck was fitted with dual controls so that it could be driven from the right or left seat. It was also was fitted with a MacDonald Johnston Mark IV slide loader unit on the left hand side. The waste collection side arm of the slide loader unit was able to be operated from controls inside the cabin or from an exterior control accessible through the left hand side door of the cabin.

6. On 28 June 2004, Ms Kati was late for work. She left the yard at about 6.20am. The evidence indicates that Ms Kati was driving her truck from the left hand drivers seat. No one is known to have seen her or her truck after this time.

7. At 9.30am on 28 June 2004, a street sweeper found Ms Kati unresponsive crushed between the extended telescopic slide arm of her waste collection truck and a power pole outside 23 Closeburn Avenue.

8. Ms Kati died from crush injuries to the chest. Toxicological analysis detected delta-9-tetrahydrocannabinol at 19ng/mL.

9. John Lambert was an independent expert witness retained by WorkSafe Victoria to provide a report in relation to its investigation of Ms Kati's death. Further, Senior Constable Simon Borg assessed Ms Kati's truck after she died. These reports were provided to me as part of the coronial brief. [9]

10. In 2003, John Merritt, Executive Director, WorkSafe Victoria, acknowledged the importance of the work Ms Kati was performing and the dangers associated with that work when he wrote:

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[8] Ms Kati had driven the same vehicle on 1, 2, 3, 4, 7, 8, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25 June 2004.

[9] I am aware that Brambles Australia Ltd commissioned two investigation reports in relation to the incident in which Ms Kati died. In the absence of an Inquest, I have not called for these reports and I am unaware of their contents.

"The collection of waste is vital work that ensures our communities remain pleasant environments in which we live. It has also been, however, a significantly hazardous industry in which to work." [10]

11. Therefore, it is important that the Victorian community learns from the circumstances surrounding Ms Kati's death. These include:

    - Recruitment, Training & Supervision; and
    - Equipment.

12. I will conclude with recommendations intended to prevent other people dying for the reasons Ms Kati died.

Recruitment, Training and Supervision

13. Ms Kati had been working for M.A.D as a Cleanaway waste collection driver/operator in the City of Stonnington for about one month when she died. She held a Victorian heavy rigid drivers licence current to 6 April 2011.

14. Ms Kati's previous employers said :

    "Lovely girl. Well liked by employers and co-workers, nice friendly attitude...

    Very punctual...

    Happy go lucky friendly personality always smiling and generally in a positive mood."

    and

    "Good honest worker, always willing to help others, reliable and well respected...

    Nice lady, quiet sort of person, didn't hear much from her just went ahead and did her work...

    Always on time for work never late"

[10] John Merritt, Executive Director, WorkSafe Victoria, "Non-Hazardous Waste and Recyclable Materials: Occupational Health and Safety Guidelines for the Collection, Transport and Unloading of Non-Hazardous Waste and Recyclable Materials" June 2003.

15. Charles Fenech was Ms Kati's supervisor and the last person known to have seen her alive. He was an experienced supervisor. He had been employed by Cleanaway as an operations supervisor for about 14 years. Mr Fenech was employed by Cleanaway to manage their operations at the City of Stonnington.

16. Mr Fenech had formed a high opinion of Ms Kati's capacity to perform her work. For example, he stated:

> *"From the day she was employed she was happy excellent employee and she was very competent in her work. She did not have any incidents or problems".*

17. Ms Kati was also assessed by M.A.D. and by John Reid for Cleanaway as:

> *"Gaylee comes to Cleanaway as an experienced driver/operator and after spending time with Gaylee, feel she should be able to complete her duties without any problems. Very good!"*

18. Therefore, Mr Fenech's opinion is supported by her referees and other pre-employment assessors.

19. However, analysis of Ms Kati's records indicates that she provided conflicting information to her M.A.D. and Cleanaway about her relevant work and accident history:

- Ms Kati told M.A.D. that she had about 18 months experience in 2002-3 driving a truck equipped with a waste bin collection arm for Waste Works. However, her self reported occupational history provided to Cleanaway indicates she worked for Waste Works for 12 months from April 2002 to April 2003.

- Ms Kati also told M.A.D. she had worked for Doug Hayes Transport for seven months from May 2003 to December 2003 delivering packages and pallets around Melbourne. However, there is evidence that she was unable to work between 7 September and 15 October 2003 or between 9 November 2003 and January 2004. This means that, even if Ms Kati worked for Doug Hayes Transport for two weeks in October, her work experience with that employer was only about four months.

- In the Cleanaway Driver Analysis Answer Sheet, Ms Kati indicated she had two prior work-related injuries. One involved '*fell through a hole in back of truck scraping shin.*" The

other involved partial loss of her right thumb in 1978. However, Kellers Recruiting & Retention Success System Driver Analysis for Cleanaway Brooklyn terminal indicated that Ms Kati also had two accidents in 2003. One involved a front right hand clipped the trailer. The other involved a side arm at full extension damaging the rear of a car. These accidents are not the same as and are extra to the injury-related incidents she reported to Cleanaway. They are also relevant to her suitability for employment as a waste collection driver/operator.

20. Therefore, I am not confident about the accuracy with which Ms Kati reported her driving experience and work-related accidents in her applications to and assessments by M.A.D. and Cleanaway. I am also concerned that inconsist5encies between her reports do not seem to have been identified and included in assessments of Ms Kati's suitability for the position she was offered.

21. As well, Cleanaway submit that Ms Kati's assessment score of 75 was extremely high. They say only eight candidates have ever achieved a score over 70.[11] Therefore, Cleanaway expected she would be a conservative, diligent and dependable driver.

22. However, questionnaire assessments of Ms Kati's attitude to work also included the following safety concerns:

> *"Seeing some safety regulations as superficial."*
>
> *"Forgetting to take care of truck maintenance if focussing on something else."*
>
> *"Accepting unsafe or broken equipment instead of voicing concerns."*
>
> *"Projects the appearance of not caring about performance."*

23. Therefore, I am not convinced that the Cleanaway assessment tools were accurately interpreted to predict Ms Kati's risk when performing unsupervised recyclable collection tasks.

24. The Certificate of Completion of the Trainee Operator Training Check List completed for Ms Kati also included ability to recognise and report faults. Ms Kati reported faults on her truck on 9 and 25 June 2004. On both these occasions, no fault was identified.

[11] I do not know how many candidates they had assessed or what proportion of candidates this number constitutes.

25. On 25 June 2004, Ms Kati's complaint involved:

"No throttle advance at times and delay on lifter"

26. Therefore, I am not convinced that Ms Kati was properly operating the lifter on the side loader unit of her truck on the last day she drove her truck before the day she died.

27. Alternatively, Ms Kati had recognised an intermittent fault that was not able to be confirmed by MacDonald Johnson and became activated at the time she died or changes in the wiring of the transistor controlling the side arm implemented by MacDonald Johnson on 25 June 2004 changed the proper operation of the side arm and/or Ms Kati's perception of its reliability.

28. Further, on 18 June 2004, Ms Kati contacted M.A.D. because she was running late for work. They contacted Mr Fenech. However, there is no indication in the Cleanaway records that Ms Kati was late for work that day and no reason was given.

29. Accordingly, when all these examples are aggregated and considered together, I am not confident that Ms Kati's reputation as a punctual, reliable, safety conscious waste collection driver/operator was entirely justified.

30. On Monday 28 June 2004, Ms Kati was late for work again. There is no evidence before me as to the reason for her being late or her behaviour over the previous weekend.

31. At 6.20am on 28 June 2004, after having coffee with Mr Fenech, Ms Kati left the Cleanaway Stonnington yard to begin collecting recyclable waste from streets on her usual round.

32. No one is known to have seen her after that time. There is no information before me as to the distance she had driven or the number of bins she had emptied.

33. After her death, Ms Kati was found to have delta-9-tetrahydrocannabinol in her blood at levels consistent with her having used cannabis in the last two hours, that is after she left the depot and while she was thought to be working.

34. I understand that Ms Kati's work at the City of Stonnington required her to drive and operate her truck without direct supervision. However, mobile supervision is not impossible and is used in other mobile tasks including policing and, it seems, street sweeping. I wonder whether Mr Fenech was restricted in his capacity to perform this role by the requirement for him to also operate a recyclable collection truck with his own route.

35. Expert evidence also indicated that the level of cannabinoids in Ms Kati's blood would have affected her capacity to perform complex tasks including driving and, by extension, manipulating bins for collection of household waste and operating the MacDonald Johnston Mark IV side loader unit in.

36. Accordingly, although I am unable to say whether she drove her truck after using cannabis, I find that cannabis influenced the incident in which she died.

37. In the context of Ms Kati's behaviour on the morning of 28 June 2004 and her previous assessments, I have formed the opinion that more flexible mobile supervision would have reduced the likelihood that she would use cannabis on the job and reduced the risk of her leaving her cabin without disengaging the gears and engaging the hand brake. **Recommendation 1**

38. Under their contract with the City of Stonnington, Visy and Cleanaway were obliged to ensure that Ms Kati and other waste collection driver/operators were not under the influence of any drug which could impede their ability to safely and efficiently perform the Recyclables Collection Service.

39. However, Mr Fenech admitted that he had no experience with managing drug use in the workplace and would not have recognised that Ms Kati was influenced by the drug.

40. Mr Fenech was not alone. Review of the National Coroners Information Service revealed only one other workplace incident in which the victim had high levels of cannabinoids in his blood.[12]

41. The circumstances of Damian des Barres' death were not dissimilar to those of Ms Kati's death: He was working for Nationwide Towing when he drove an excavator on to a trailer. The excavator lost traction on the surface of and slid off the trailer killing Mr des Barres. Mr des Barres was found to have a delta-9-tetrahydrocannabinol concentration of 39ng/ml when he died. This drug use had no influence on the charges laid against Nationwide Towing under the *Occupational Health and Safety Act* 2004.

[12] Coroners Case 20/07.

42. These two deaths and the recognised effects of cannabis use on skilled performance indicate to me that supervisors of employees performing skilled tasks need to be aware of the effect it has on performance and risk. **Recommendation 2.**

Equipment

43. In 2004, the *Occupational Health and Safety Act* 1985 was in operation. Its aim was to reduce death and injuries in the workplace. [13]

44. Section 3 of the *Occupational Health and Safety Act* 1985 defined the "workplace" as any place, whether or not in a building or structure, where employees worked.

45. Further, section 25(1) of the *Occupational Health and Safety Act* 1985 imposed a duty on employees:

"(1)While at work, an employee must—

(a) take reasonable care for his or her own health and safety and for the health and safety of anyone else who may be affected by his or her acts or omissions at the workplace..."

46. Ms Kati was personally responsible for performing her work in a manner that did not unreasonably place her in danger.

47. Investigation of Ms Kati's death proceeded on the presumption that the park brakes on her truck were the main mechanical factor contributing to her death.

48. Mr Lambert concluded that Ms Kati probably failed to properly apply the hand brake before she left the cabin so that it slipped into a position where it became ineffective and allowed her truck to move forward and crush her.

49. However, Mr Borg checked the brakes on Ms Kati's truck on the day of the incident. He found no fault with the park brake system which may have caused or contributed to the collision.

[13] Unless otherwise stated, the effect of relevant provisions continued in the *Occupational Health and Safety Act* 2004 which came into operation on 1 July 2006.

50. Further, the park brake on Ms Kati's truck was not influenced by modifications to import the MacDonald Johnston Mark IV side loader bin lifter. Therefore, the controls and safety features of the park brake remained those implemented by Volvo.

51. Therefore, I find it most unlikely that any failure in the park brake system of Ms Kati's truck has not also occurred in other Volvo trucks. There is no evidence before me that this has occurred.

52. Further, Ms Kati failed to disengage the 'drive' gear on her truck before she vacated the cabin. In my opinion, this failure reduces the likelihood that she went through the routine movement of disengaging the automatic gears and activating the hand brake.

53. Accordingly, I am unable to conclude that Ms Kati died because the park brakes on her truck failed while she was moving an inaccessible bin so that the extended side arm on the slide loader unit crushed her against the tree.

54. On the contrary, whatever the operational status of the side arm, I have formed the opinion that Ms Kati left the truck cabin through the left hand door without engaging the hand brake while the truck was still in "Drive" gear.

55. Accordingly, Ms Kati would not have died if she had operated the hand brake and put the truck gear into neutral before she left the cabin even if the side arm was not working properly.

56. Mr Fenech said that the safe operating procedures for picking up an inaccessible bin advocated by Cleanaway were:

- stop the truck,
- apply the park brake,
- put the gears into neutral,
- get out of the vehicle through the left hand door,
- move the bin from the obstruction to a clear position,
- hop back into the vehicle, and

- use the internal controls to operate the side arm and empty the bin into the hopper on the side of the truck.

57. If Ms Kati had adhered to this operation on 28 June 2004, she would not have died. To the extent that she knew but failed to comply with Cleanaway operating procedure, Ms Kati was responsible for her own death.

58. However, section 21(1) of the *Occupational Health and Safety Act* 1985 also provided:

"(1) An employer shall provide and maintain so far as is practicable for employees a working environment that is safe and without risks to health....

For the purposes of subsections (1) and (2)—

(a) a reference to an employee includes a reference to an independent contractor engaged by an employer and any employees of the independent contractor; and

(b) the duties of an employer under those subsections extend to an independent contractor engaged by the employer, and any employees of the independent contractor, in relation to matters over which the employer has control or would have control if not for any agreement purporting to limit or remove that control."

59. Accordingly, M.A.D. and Cleanaway were also responsible for ensuring Ms Kati worked in a safe environment so far as was practicable.

60. However, inclusion of an outside control facility for the MacDonald Johnston Mark IV side loader unit in the design of Ms Kati's truck and training of the waste collection driver/operators in use of the external joystick implies that the safe operating procedures advocated by Mr Fenech were not always appropriate in practice.

61. Further, Ms Kati and her colleagues did not always comply with the safe operating procedures described by Mr Fenech. In particular, on 9 June 2004, Ms Kati reported that the external joystick was not operating properly. This means she must have used or attempted to use the external joystick on that day soon after her training was complete.

62. Therefore, Mr Fenech knew or should have known that Ms Kati had used or attempted to use the external controls to operate the slide loader unit on at least one occasion in the four weeks

she was working for Cleanaway. There is no evidence that he counselled her about this practice.

63. Further, Ms Kati had only worked using their Cleanaway equipment for four weeks. Although, in Mr Fenech's opinion she was a happy excellent employee and she was very competent, the evidence is that she was not always reliable in her work.

64. In particular, Ms Kati had only been working on the City of Stonnington project for one month. She was late for work on the day she died and on another morning during the week before she died. She was affected by cannabis. She had been assessed as:

> *"Seeing some safety regulations as superficial."*
>
> *"Forgetting to take care of truck maintenance if focussing on something else."*
>
> *"Accepting unsafe or broken equipment instead of voicing concerns."*
>
> *"Projects the appearance of not caring about performance."*

65. In submissions, the Metropolitan Waste Management Group ("MWMG") understands that Ms Kati would have been protected if the truck was fitted with an emergency brake that engaged when the driver exited the truck cabin without engaging the hand brake. I agree.

66. Alternatively, MWMG has suggested that an alarm could be fitted to the emergency brake as a reminder to the driver that they have left their vehicle with the hand brake unengaged and the gears engaged. They say that a skilled operator may only need this reminder to ensure their safety.

67. In the circumstances involved in Ms Kati's death, it seems that an alarm may not be as practical as a hard-wired emergency brake.

68. Cleanaway have indicated that they are in the process of including a "Maxi brake" that engages if the driver exits the cabin while operating it in left hand drive without engaging the handbrake. They anticipate that all their domestic side loader vehicles will be fitted with the maxi brake by June 2013.

69. Whatever, the reason for Ms Kati's truck continuing to move after Ms Kati left the cabin, the "Maxi brake" would have prevented her death. Accordingly, I support the implementation of this initiative. **Recommendation 3.**

70. Further, the WorkSafe Victoria Guidelines advise use of control mechanisms that cease all movement when released and emergency stops that are clearly labelled and coloured.

71. Although there was an emergency stop button in the cabin connected to the slide loader unit on Ms Kati's truck, there is no evidence of an emergency stop button accessible from outside the cabin. **Recommendation 4**

72. From the M.A.D. perspective, Mr Wilcox was complying with his occupational health and safety obligations when he inspected the Brooklyn worksite at Cleanaway Stonnington on 1 April and 30 June 2004. He consistently recorded cleaning, maintenance, guarding and stop/start buttons on the machinery, vehicle and warehousing as not applicable.

73. However, he specifically noted that the vehicles were not relevant to his inspections. Therefore, I have formed the view that Mr Wilcox did not consider that the trucks used by M.A.D. employees were relevant to his occupational health and safety responsibility to protect Ms Kati as his employee.

74. M.A.D. have amended their Risk Management Policy since 2004. Under this new policy, they continue to perform quarterly safety audits on host work sites to identify hazards that may affect their employees. However, they now use an independent third party inspection where practicable.

75. I am not aware of Mr Wilcox's expertise in undertaking occupational health and safety investigations. However, presuming the changes in M.A.D. policy imply use of an expert occupational health and safety investigator, they will overcome any failure to understand that the vehicles used by employees constitute part of their "workplace". Accordingly, I make no recommendations on this issue.

76. The in-cabin control box in Ms Kati's truck included a bin lift selector switch and an external control light which would have indicated whether or not she was using the external controls when she died. However, there is no evidence before me as to the status of the bin-lifter

selector switch or the status of the external control light indicator in Ms Kati's truck on 28 June 2004.

77. Accordingly, I remain reluctant to accept that Ms Kati used or intended to use the internal control mechanism to extend the slider arm of the bin lifter before she left the cabin of her truck on 28 June 2004.

78. Further, although MacDonald Johnston checked Ms Kati's truck after her death and found that the slide arm and bin lifter retracted normally when the truck speed reached 4kph, neither Mr Lambert nor Mr Borg independently assessed the operation of the MacDonald Johnston Mark IV side loader unit on Ms Kati's truck.

79. Therefore, in the context of Ms Kati's complaint about its operation on 25 June 2004 and changes in the wiring of the transistor controlling the side arm implemented by MacDonald Johnson that day, I am also unable to exclude the possibility that malfunction of the MacDonald Johnston Mark IV side loader unit on Ms Kati's truck contributed to her death.

80. In June 2004, side loader bin lifters on road side recyclable collection vehicles were a new initiative in road side waste collection. When Ms Kati died, they had only been in routine operation in the City of Stonnington for about two months. Ms Kati had been using the side loader bin lifter for four weeks.

81. On 9 June 2004, the monitoring process for the new program reported that the list of outstanding items was already too large to manage and requests had been outstanding for too long. They also recorded that the initial honeymoon period was coming to an end.

82. Therefore, the inexperience of all those involved in implementing the new program would seem to be a contributory factor in Ms Kati's death. In these circumstances, the safety issues relating to new equipment become accentuated.

83. Mr Lambert raised the possibility that the MacDonald Johnston Mark IV side loader unit could be designated as "plant" for the purposes of Regulation 106 of the Occupational Health and Safety (Plant) Regulations 1995. He also said that, if it applied at all, this definition of "plant" only applied if the side arm was operated from the external controls.

84. Under the *Occupational Health and Safety Act* 1985 and associated regulations, designers of equipment had a duty to eliminate any risk associated with use of plant. Where elimination is

not possible, designers are obliged to reduce the risk as far as is possible and to ensure guarding of plant, incorporation of warning devices and inclusion of emergency stops.

85. However, Regulation 106 of the Occupational Health & Safety (Plant) Regulations 1995 only applied to:

> *" plant that lifts or moves people or materials (other than a ship, boat, aircraft or, except as provided in sub-regulation (4), a vehicle designed to be used primarily as a means of transport on a public road or rail)".*[14]

86. Therefore, there is good reason to doubt that the operation of the MacDonald Johnston Mark IV side loader bin lifter on Ms Kati's truck was covered by the provisions of the *Occupational Health and Safety Act* 1985 and associated regulations which placed responsibility on designers for ensuring its safe operation.

87. I am unable to say whether or not WorkSafe Victoria believed it had authority under the Occupational Health & Safety (Plant) Regulations 1995 to investigate the liability of designers of the MacDonald Johnston Mark IV side loader unit and/or whether these regulations explained their failure to consider the possibility that design of the side loader was a contributory factor.

88. However, when new equipment is commissioned, the safety of novice users of new equipment relies heavily on the designers' duty to identify and, where possible, eliminate any risk associated with its use.

89. Therefore, the Government of Victoria should amend the current Occupational Health & Safety (Plant) Regulations 2007 to ensure that waste collection equipment, like the MacDonald Johnston Mark IV side loader unit, which is mounted on a vehicle used primarily as a means of transport on a public road is not excluded from the provisions that impose occupational health and safety obligations on the designers of that equipment. **Recommendation 5.**

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[14] This definition was continued when these Regulations were replaced by the Occupational Health & Safety Regulations 2007.

RECOMMENDATIONS

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

I recommend that

1. Cleanaway appoint a full-time supervisor to provide greater supervision of waste collection driver/operators performing recyclable waste collection tasks.

2. Cleanaway better educate operational supervisors to increase their awareness of the effect of cannabis on skilled performance and risk and ensure appropriate responses to suspicions that cannabis is an issue in the workplace.

3. Cleanaway continue to fit all their domestic side loader vehicles with a "Maxi brake" that engages if the driver exits the cabin while operating it in left hand drive without engaging the handbrake.

4. Cleanaway ensure that there is an emergency stop button on their domestic side loader vehicles which is accessible from outside the cabin.

5. The Government of Victoria amend the definition of "plant" in the Occupational Health & Safety (Plant) Regulations 2007 to ensure that equipment mounted on a vehicle used primarily as a means of transport on a public road is not excluded from the provisions that impose duties on the designers of that equipment.

I order publication of this finding on the Internet.

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

Minister for WorkSafe Victoria

Minister for Transport

Chief Executive Officer Metropolitan Waste Management Group

Chief Executive Officer Municipal Association Victoria

Chief Executive Officer City of Stonnington,

Chief Executive Officer M.A.D. Recruitment,

Chief Executive Officer WorkSafe Victoria

Chief Executive Officer Cleanaway Global Waste Management

General Manager, MacDonald Johnston Engineering Pty Ltd.

Signature:

DR JANE HENDTLASS
CORONER
Date: **21 January 2013**