IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2008 4550

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of GREGORY JON ANDREWS

without holding an inquest:

find that the identity of the deceased was GREGORY JON ANDREWS

born 13 November 1957

and the death occurred on 8 October 2008

at McCutcheon Street, Northcote VIC 3070

from:

1 (a) MULTIPLE CRUSH INJURIES TO THE NECK AND CHEST (WORKPLACE ACCIDENT)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Gregory Jon Andrews was 50 years of age at the time of his death. He lived in Officer with his wife, Renee Bentley-Andrews. From the age of 18 years, Mr Andrews had worked extensively as a truck driver.

2. On the morning of 8 October 2008, Mr Andrews was standing between his truck and a semi-trailer that were parked side by side. Both vehicles were facing east on McCutcheon Street, Northcote, approximately ten metres from the intersection with High Street. Mr Andrews' vehicle or 'crane truck' had a Fassi crane (model F170A.22) attached to the back. His crane truck was parked on the south side of the road, and the two trucks were blocking the road. Mr Andrews was using the controls on the passenger side of his truck, between the two vehicles, to

control the crane and lift a load of 3.4 tonne steel coils off the second truck (a semi-trailer). As Mr Andrews lifted the load, it caused his crane truck to tip over, catching him between the two vehicles. The wheels on the driver's side of his truck were in the air. After the crane truck moved back and forth, Mr Andrews was released from between the trucks, and fell to the ground.

3. Emergency services were called at approximately 7.45am and two bystanders began performing cardiopulmonary resuscitation (CPR) on Mr Andrews. Police were first to attend and took over performing CPR. More police officers arrived followed by two ambulances. After attempting to render assistance and being unable to find a pulse, ambulance paramedics declared Mr Andrews to be deceased.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination on the body of Mr Andrews and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of post mortem blood did not identify any common drugs or poisons.

5. Dr Bedford ascribed the cause of Mr Andrews' death to multiple crush injuries to the neck and chest in a workplace accident.

Police investigation

6. The circumstances of Mr Andrews' death have been the subject of investigation by Victoria Police on my behalf. The police investigation found that Mr Andrews' vehicle had been equipped with stands to help when lifting heavy items from the tray, and the driver's side stands were extended out onto a grassed area of the adjacent construction site. The stands on the passenger side were unable to be extended, due to the proximity of the semi-trailer.

7. Police obtained a statement from Mr Andrews' wife Mrs Renee Bentley-Andrews. She reported that Mr Andrews had worked as a truck driver for TCB Trans Pty Ltd (TCB) since approximately 2004. When TCB had obtained a crane truck a few years later, Mr Andrews was assigned to drive and operate it on a daily basis.

8. Mrs Bentley-Andrews reported that occasionally over the years, Mr Andrews had come home and complained that TCB or Selection Steel, a company he delivered rolls of steel to, had tried

to overload him. Mr Andrews had suspected at times that the load in his truck was heavier than the weight noted on dockets provided to him.

9. In around March 2008, Mrs Bentley-Andrews stated that Mr Andrews had resigned from TCB, after becoming dissatisfied with his wages and interactions with some staff at the business. However, he had been convinced by the owner, Don Madafferi to stay on. Since this event, Mrs Bentley-Andrews had observed that her husband was happier at work. She added that Mr Andrews had been very safety conscious and knowledgeable about his WorkSafe priorities.

10. Mrs Bentley-Andrews reported that when Mr Andrews had left home at dawn on 8 October 2008, he had seemed fine and had not appeared tired or agitated.

WorkSafe Investigation

11. As Mr Andrews' death occurred in the course of his employment, the Victorian WorkCover Authority (or WorkSafe) conducted an investigation into the circumstances of his death. Buildcorp Commercial Pty Ltd (Buildcorp) was the principal contractor on site, and Jelena Hall Pty Ltd had been formed to provide contract labour to Buildcorp under a services agreement. The contract labour included Mr Leigh Coles, who was the site foreman and whose responsibilities included management of contractors at the site. Buildcorp and Jelena Hall had the same directors and share the same registered business address. Mr Andrews' employer, TCB, had been brought in on 8 October 2008 to provide a crane truck and operator. There was no written contract between TCB and Buildcorp.

12. WorkSafe obtained statements from the driver of the semi-trailer Michael Cooper, Buildcorp Labourers Jarrod Heenan and Adam Carr, Interspan Victoria Pty Ltd Steel Fixer Andrew Kirk, Doire Formwork Carpenter Darran McFlynn, Grocon Operations Logistics Coordinator Russell Anderson, Melbourne Prop Hire Pty Ltd Director Paul Clarke, Grocon Site Supervisor Michael Flatman, Hiab Australia Pty Ltd Victorian State Manager Aaron Nicholson, Licensed Surveyor Bryan Walsh, Managing Director of Alltrac Pty Ltd and Engineer John Hambridge, and WorkSafe employees: Licensing Compliance Auditor Alois Kapeller, Licensing Branch Worker Stuart Heydon, Senior Inspector Joseph Barcellona, Inspector Charles Grech, Senior Investigator William Murphy and Senior Investigator Steven Zmak.

Previous safety focus

13. Mr Anderson reported that when he had used the TCB crane truck at a fabrications yard in Broadmeadows, he had observed that Mr Andrews was one of the safest truck drivers he had ever seen and would take extra care to load a truck and make sure it was secure. Mr Clarke said

that when his company had used Mr Andrews' services he had always had the outriggers extended.

The incident

14. Mr Heenan reported that the construction site on the corner of High Street and McCutcheon Street Northcote was being developed into an apartment complex. Mr Heenan said that Mr Coles' site specific induction as foreman for the Northcote site would normally run for 20 to 30 minutes and covered Safe Work Method Statements relevant to tasks, hazard identification and other matters.

15. On the afternoon of 7 October 2008, Mr Heenan reported that Mr Coles had told him that he had organised for the hire of a crane truck and operator the following day, to unload another truck delivering materials for the site. Mr Heenan said that Mr Coles told him that the trucks were to set up on McCutcheon Street, and that they were to set up back to back or end to end, so that the rear of the trucks would be aligned. Mr Heenan reported that Mr Coles said the crane truck was appropriate for the task, and that he had discussed it with the crane truck company. They did not discuss specific weights and Mr Heenan did not sight any paper work for the delivery.

16. When Mr Heenan started work at the Northcote site at 7.00am on 8 October 2008, he noticed a small black four wheel drive vehicle was parked in McCutcheon Street, close to High Street. He had thought that the vehicle might leave by the time the two trucks arrived. However, when the two trucks arrived, Mr Heenan noticed that the black vehicle was still parked in the side street on the south side of the road.

17. Mr Cooper said that he had never had his semi-trailer unloaded by a crane truck before and had discussed the process with a representative from Buildcorp and Mr Andrews on the morning of 8 October 2008. The crane truck was parked behind a black car on McCutcheon Street at this point, and the Buildcorp representative had said the driver of the black car usually left each morning. Mr Cooper said the plan at that stage was that he was going to back the semi-trailer in behind the crane truck, so they were tail-to-tail for the unloading. However, the black car did not move and remained in the way.

18. Mr Heenan reported that he, Mr Coles, Mr Cooper and Mr Andrews discussed how the unloading would occur given the black vehicle was in the way. Mr Heenan said that as they could not run with the original plan of unloading the trucks back to back, together they discussed alternatives.

19. Mr Heenan reported that someone, he was not sure who, suggested that they could unload the semi-trailer with both trucks double parked in the street. Mr Heenan said Mr Coles told him that Mr Andrews did not want to unload while double parked, because it would block the road. Mr Heenan suggested diverting traffic from the area. Mr Heenan said that Mr Andrews indicated he was okay to unload while double parked, if the traffic was being redirected. Mr Cooper reported he was told that the crane truck would move, so it was tail to tail with the black car. Mr Cooper was told to bring his semi-trailer alongside the crane truck for the unloading.

20. Mr Heenan and Mr Carr removed part of the wooden hoarding on the north site boundary of the construction site so that Mr Andrews could extend the outrigger of the crane truck on the driver's side.

21. After Mr Cooper had parked next to the crane truck as planned, he reported that only he and Mr Andrews were out on McCutcheon Street. Mr Heenan was manning the High Street end of McCutcheon Street, Mr Carr was directing traffic at the cabin ends of the trucks, and Mr Coles was on the site with an Interspan employee, standing where the material was going to be landed.

22. Mr Cooper placed the chains of the crane around the coil and back up to the crane hook. At this point, Mr Andrews was operating the crane from the controls located on the side closest to the semi-trailer, so that he was standing between the two trucks. Mr Cooper stood at the rear of the semi-trailer, on the side closest to the crane truck.

23. Thinking Mr Andrews had the load under control, Mr Cooper watched the coil get higher and then gradually get lower, and at that point he could hear people screaming from the construction site. Mr Heenan saw that the crane truck was tilting away from the construction site towards the semi-trailer.

24. Mr Cooper watched the crane truck hit his semi-trailer and wedge Mr Andrews between the two trucks. The give provided by the chains on the coil allowed the crane truck to rock back and forth in a sideways direction, so that Mr Andrews was released from in between the two trucks and fell to the ground.

WorkSafe attendance and issuing of Improvement and Prohibition Notices

25. Senior WorkSafe Inspector Barcellona attended the incident site at 8.45am on 8 October 2008. He noted that having the outrigger not equally extended on both sides had contributed to the crane truck overturning and was informed no formal documented procedure existed for the use

of the crane truck. Senior WorkSafe Inspector Barcellona issued a Prohibition Notice to TCB as a result of this information.[1]

26. Senior WorkSafe Inspector Barcellona observed that there were no indications of any traffic control being undertaken during the unloading process, and was advised that there was no system in place that ensured loading and unloading activities involving the crane truck were undertaken in a safe manner. On the basis of this information, he issued an Improvement Notice to TCB.[2] Senior Investigator Zmak subsequently arrived at approximately 9.00am.

27. WorkSafe Inspector Grech attended the site at 9.15am. He formed the opinion that Buildcorp was performing high risk construction work - unloading the material from the semi-trailer using a crane truck on a residential street, with risk to road and pedestrian traffic and employees - without a Safe Work Method Statement.[3] Buildcorp were unable to provide evidence that a Safe Work Method Statement had been prepared for the unloading activity. WorkSafe Inspector Grech issued an Improvement Notice[4]

28. WorkSafe Senior Investigator Murphy attended the site at 9.50am and noted that a block of wood was resting at each position, where the base of the outrigger ram support pads would have been located prior to the lifting and unloading operation.

29. On 14 October 2008, Inspector Grech attended the incident site and sighted a documented Safe Work Method Statement for the use of a crane truck, along with a documented traffic management system for unloading and loading activities. Inspector Grech deemed his previously issued Improvement Notice to be complied with.

30. On 3 December 2008 Senior WorkSafe Inspector Barcellona met with Domenic Madafferi,[5] Director of TCB to follow up on the Improvement Notice in relation to the systems of work

[1] The Prohibition Notice V00016302492L/112-02 related to 'Loading and unloading activities with crane mounted trucks without a documented safe work procedure.' Another Prohibition Notice V00016302492L/112-01 was also issued to TCB on this day in light of the fact that the Fassi crane or outrigger arms may have sustained damage during the incident, which could present an immediate risk if the unit collapsed or failed when subsequently used to lift loads.

[2] The Improvement Notice V00016302492L/111-01 required remedial action by TCB to 'so far as is reasonably practicable provide a safe system of work associated with the loading and unloading of items using the truck mounted crane.'

[3] This was contrary to Regulation 5.1.9(1) of the Occupational Health and Safety Regulation 2007, which requires an employer to prepare a Safe Work Method Statement before commencement of high risk construction work if there is a risk to health or safety of any person arising from the work.

[4] The Improvement Notice V00053301827L/111-01 required that Buildcorp Commercial Pty Ltd must develop a Safe Work Method Statement for the use of a crane truck to unload a coil of post tensioning cable from a semi-trailer.

[5] I note that in other sections of the WorkSafe brief, Mr Madafferi is referred to as 'Don Madafferi'.

associated with loading and unloading activities. He was informed that systems of work had been developed, documented and implemented, including Safe Work Method Statements for new sites, an induction program, a procedure for vehicle mounted crane operation and bollards / signage. Initial training had also been undertaken in relation to the new system of work and was to be provided to all employees. Senior WorkSafe Inspector Barcellona deemed his earlier Improvement Notice to be complied with.

31. On 6 February 2009, Senior WorkSafe Inspector Barcellona and WorkSafe Inspector John O'Brien attended TCB offices to follow up on the Prohibition Notice. They were informed that a Typical Vehicle Mounted Crane Operational Layout procedure had been prepared, which provides safe set up and operation instructions for crane operators. The procedure also incorporates site based risk assessments and Safe Work Method Statements. Mr Madafferi advised that drivers had been instructed that they were to refrain from any unloading / loading activities if they felt they or anybody else was at risk. He also advised that TCB crane truck operators were attending training courses for vehicle mounted cranes. On the basis of this information, the immediate risk specified in the Prohibition Notice was deemed to be remedied.

32. However, a further Improvement Notice was issued in relation to the fact TCB had implemented administrative controls, rather than higher order controls, such as a stabiliser interlocker device, which can be fitted to crane trucks to prevent the crane being operated unless the outriggers are fully extended. On 17 April 2009, this subsequent Improvement Notice was deemed complied with, after TCB had purchased a radio control device that enables the crane to be operated remotely.[6]

Training and licensing issues

33. Hiab Australia Pty Ltd Victorian State Manager Mr Nicholson stated that his company had fitted the Fassi 170 Crane for TCB, and that it is general practice that familiarisation training is offered to companies on the sale of new and used equipment, or in this case in the fitting of cranes to plant. Familiarisation training covers paper work, overview of crane, set up, use of controls, picking up a load and folding up a crane, but is not designed to replace specific operator training requirements or licensing. However, Mr Nicholson confirmed Hiab Australia Pty Ltd do not have any documentation detailing the familiarisation training provided to TCB in relation to fitting the Fassi 170 crane.

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[6] While the radio control device still enabled the crane to be used without the outriggers being engaged, a decision made by WorkSafe's Internal Review Unit meant that the Improvement Notice was affirmed with variation.

34. In its Statement of Material Facts, WorkSafe observed that under Regulation 3.6.1 of the *Occupational Health and Safety Regulations 2007* (OHS Regulations), a person can only do high risk work if they hold a high risk licence in relation to the work. In addition, employers must not use unlicensed employees to do high risk work.[7]

35. Mr Kapeller noted that the operator of a vehicle loading crane which has a capacity of greater than ten metre tonne must hold a licence for high risk work, according to the OHS Regulations[8]. Mr Hambridge noted that the Fassi 170A.22 model crane involved in the incident is considered to be a 17 metre-tonne crane. The class code for the licence is CV, which is an acronym for crane vehicle loading. To obtain a CV licence, a person must undertake a competency assessment against the National Assessment Instrument for Vehicle Loading Crane (NAVLC) and National Assessment Instrument for Cranes Written, both published in August 2000. Mr Kapeller added that prior to undertaking the assessment for a CV licence, a person will generally undertake training at a TAFE or similar facility.

36. Mr Kapeller reported that page 6 of the NAVLC outlines the practical tasks that the operator needs to demonstrate when setting up the crane, including the specific requirement for extending stabilisers as per the manufacturer's specification and also the correct packing under stabilisers. Page 14 outlines the knowledge requirements for the operator in relation to setting up the crane, including the use of stabilisers.

37. Mr Heydon searched the WorkSafe database in relation to Mr Andrews and whether he had attained WorkSafe Licences to perform high risk work. He reported that Mr Andrews had never held a Certificate of Competency or a Licence to Perform Risk Work, and had never applied for any class, specifically not for a Vehicle Loading Crane with a capacity of 10 metre tonne or more.

Expert Engineering Report

38. Engineer John Hambridge reviewed extensive material and provided a technical report in relation to the incident, dated August 2009.

39. Mr Hambridge concluded that the crane was in good order; it was relatively new and exhibited little sign of either significant usage or undue wear. However, he noted that it appeared that the Electronic Lifting Moment Limiting Device had effectively been disabled and that this had

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[7] Regulation 3.6.2, OHS Regulations

[8] Schedule 3, OHS Regulations

occurred sometime prior to the incident. However, it was Mr Hambridge's view that the disabling of this safety device did not directly affect the instability of the crane.

40. Mr Hambridge noted that Australian Standard 2550.11 requires that records of servicing, inspections and maintenance should be maintained. In the case of TCB, he found that maintenance records were not comprehensive. The lack of a log or daily check book suggested that faults were not recorded and appropriate remedial actions could not be carried out.

41. However, in relation to the incident itself, Mr Hambridge summarised the contributing factors which led to the vehicle overbalancing as:

    - Inadequate load bearing supports were placed under the foot pad of the vertical hydraulic stabiliser cylinders.[9] Mr Hambridge noted that the relatively small sized blocks were inadequate to the task.
    - The left side stabiliser extension leg was not fully extended to its outermost position as per the manufacturer's instructions.[10]
    - The crane was operated from the left side of the vehicle and from a position between the crane and the semi-trailer being unloaded. Mr Hambridge opined that operating the crane from between the two trucks presented an unnecessary risk to Mr Andrews. Mr Hambridge further noted that the crane should be operated from a position that prevents the load being passed or lifted over the operator. Operation of the crane could have also been carried out from the right side of the vehicle. While visibility of the load would have been hampered, Mr Hambridge stated inter alia, that the crane should be sited so that the operator always has optimum vision of the work area, except where the movement of the crane is being directed by a suitably trained 'spotter', who can assist and relay information.[11] Mr Hambridge added that a 'spotter' would have assisted in this case and risk analysis would have assessed the need for this assistance.
    - Site conditions were such that the safe use of the crane was inhibited.[12] There was only a small space of approximately 400-600mm between the vehicles, so that the left stabiliser

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[9] AS2550.11 recommends the use of load bearing blocks. Mr Hambridge opined that the instability in this case would have been compounded by the use of the narrow wooden blocks.

[10] AS2550.11 also advises that the stabiliser legs should be activated as per the manufacturer's recommendations.

[11] See: 'Spotter' Trained and competent person – Australian Standard AS2550.5-2002

[12] AS2550.11 also recognises that there is an operator "exclusion zone". The crane should not be operated over the head or behind the crane operator.

could not be fully extended. Mr Hambridge noted the congested nature of the incident site, and noted that the closely located private black vehicle and relative narrowness of the street prohibited safe positioning of either the crane truck or semi-trailer. The small space between the two vehicles significantly compromised the safe operation of the crane.

42. Mr Hambridge opined that in the circumstances, the likelihood of a hazard or risk eventuating, and of personnel and operator injury occurring, was extremely high.

43. Mr Hambridge observed that there were several reasonably practical measures that could have been taken by TCB that would have reduced or eliminated the risk of the incident occurring:

    - The implementation of safe work practices, including the issuing of daily or pre-operational check books, and a plant log book, regular servicing and inspections would have significantly reduced the risks.
    - Operator retraining and supervision at various intervals could also have reduced the risk. Mr Hambridge opined that the importance of training and retraining operators of plant cannot be overstated. The manufacturers of the plant and their representatives do offer training short courses on their plant and equipment.
    - Implementation of Job Safety Analysis (JSA) or site risk assessment would also have significantly reduced the risk of personal injury. JSA templates can be downloaded from the WorkSafe website. Lists of service providers are available at this site.

44. Mr Hambridge noted that subsequent documents compiled by TCB dated 7 November 2008 were adequate examples of the necessary protocols that assist in the reduction of hazards and risks. However, Mr Hambridge understood that these were not in existence prior to the incident.

45. Mr Hambridge concluded that significant deficiencies existed in the conduct of the personnel involved in the operation, maintenance and supervision of the Fassi Crane.

Industry Standard

46. WorkSafe further noted that the industry standard, 'Australian Standard 2550, 11-2004: Cranes, hoists and winches – Safe Use Part 11: Vehicle-loading cranes', specifies requirements for safe use of vehicle loading cranes. In particular, the standard requires:

    - (Cl 1.7) Risk assessment;

- (Cl 4.2.1) Ensuring the ground or means of support means that the crane can operate within levels and parameters specified by manufacturer;
- (Cl 4.2.8) Stabilisers need to be able to be used according to manufacturer's specifications;
- (Cl 4.3.1(e)) Consideration needs to be given to hazards including personnel movement within the vehicle-loading crane working area;
- (Appendix B) Risk management involves a Safe Work Method Statement.

Prosecution of TCB Trans Pty Ltd

47. By email to the Court dated 16 January 2015, WorkSafe confirmed that on 8 December 2014, TCB Trans Pty Ltd pleaded guilty to one charge contrary to section 21(1) and 21(2)(e) of the Occupational Health and Safety Act 2004 for failing to provide a working environment that was, so far as was reasonably practicable, safe and without risks to health in that it failed to provide information, instruction, training or supervision to employees as was necessary to enable them to perform their work in a way that was safe and without risk to health. TCB Trans Pty Ltd was convicted and fined $100,000 at the Melbourne Magistrates' Court.

48. By email dated 20 January 2015, WorkSafe confirmed that TCB Trans Pty Ltd applied for summary jurisdiction, which was granted. In sentencing, Magistrate Robinson made the comment: 'It's a timely opportunity for companies to keep in mind health and safety when working in dangerous environments.'

49. By letter dated 20 January 2015, WorkSafe advised that charges against Buildcorp Commercial Pty Ltd were withdrawn at the Melbourne Magistrates' Court on 8 December 2014. By email dated 19 April 2016, WorkSafe advised that the charges had been withdrawn due to insufficient evidence.

COMMENTS

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

1. I received a letter of concern from Mr Andrews' mother, Mary Andrews, on 18 December 2014. In her letter, Ms Andrews expressed disappointment that charges against Buildcorp Commercial Pty Ltd had been withdrawn by WorkSafe. In particular, Ms Andrews noted that Buildcorp had failed to prepare the site in anticipation of Mr Andrews arriving with a crane truck, by closing

the road so that the private black vehicle was not in the way. This had meant that the crane truck could not unload the semi-trailer 'tail to tail' as planned. Ms Andrews also suggested that the semi-trailer had not been parked as closely to the kerb as it could have been, taking more space away from the crane truck and preventing the left stabiliser leg from being properly utilised.

2. WorkSafe has not elaborated to the Court upon the reasons that charges were withdrawn against Buildcorp. However, on the evidence available to me, it appears that Buildcorp, as the principal on site contractor, had not prepared a Safe Work Method Statement or alternative risk assessment in relation to the unloading of the semi-trailer by the crane truck. This is contrary to regulation 5.1.9 of the OHS Regulations, which requires that an employer must not perform high risk construction work[13] if there is a risk to the health or safety of any person arising from the work, unless a Safe Work Method Statement is prepared for the work before it commences.

3. After reading Mr Hambridge's expert report, I noticed that his comments regarding the lack of a suitably trained 'spotter', had not been highlighted in WorkSafe's Material Statement of Facts. Mr Andrews had been sent by TCB to the site as the sole operator of the crane truck. I note that the driver of the semi-trailer, Mr Cooper stated that after the trucks had been parked side by side, he and Mr Andrews were the only people out on McCutcheon Street. In his report, Mr Hambridge notes that in circumstances where the operator does not have optimum vision of the work area, the movement of the crane should be directed by a suitably trained 'spotter', who can assist and relay information. I concur with Mr Hambridge's assessment that a 'spotter' would have assisted in this case and adequate risk analysis would have assessed the need for this assistance. However, I further note that the ideal scenario would have involved Mr Andrews operating the crane from the driver's side of the vehicle.

4. The dangers of working alone in relation to large plant and lifting heavy loads of building products have arisen before in this jurisdiction. Following my investigation into the death of Ian Charles Kelly,[14] who died in similar circumstances to Mr Andrews, I commented that working alone with heavy hydraulic machinery is inherently risky, but nevertheless is more often than not, accepted practice within a number of industries. I also commented that the very nature of the presence of another colleague would have lessened the burden of implementing the

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[13] Pursuant to regulation 5.1.3, 'high risk construction work' includes construction work at places where there is any movement of powered mobile plant; and/or on or adjacent to roadways or railways used by road or rail traffic.

[14] COR 2005 1076

stabilisers in that case and also lessened any real or perceived pressure on Mr Kelly. In that case I made a number of recommendations, including that:

- The employer implement a policy that two workers be assigned for all deliveries where the use of the hydraulic crane is anticipated.
- That the manufacturer include in the operator's manual a recommendation that a spotter should always be available to the operator of the crane.
- That WorkSafe issue Safety Alerts on a regular and periodic basis, and not only in response to a fatality; on the dangers of operating hydraulic cranes, including recommendations that a spotter always be available.

5. I acknowledge the grief and suffering endured by Ms Andrews and the rest of Mr Andrews' family in the wake of his death. However, while the actions of TCB and Buildcorp appear to have been clearly inadequate and lacking adherence to occupational health and safety legislation and regulations, in some part, it appears that Mr Andrews' actions contributed to his own death. I accept that Mr Andrews was known amongst family and colleagues to be particularly safety conscious. However, in failing to stabilise the crane truck before operating the truck; placing himself between the two vehicles; proceeding without a Safe Work Method Statement or Job Safety Analysis being undertaken; failing to contact TCB for assistance when the anticipated method of unloading the coils from the semi-trailer was no longer possible in the presence of the private black vehicle; and not utilising another person as a spotter or choosing to operate the crane from the driver's side, Mr Andrews greatly increased the risk of injury to himself.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of preventing further like deaths, **I recommend** that TCB Trans Pty Ltd implement a policy that two employees be assigned for work where the use of the crane truck is anticipated, or alternatively that a suitably trained 'spotter' always be available to assist on site.
2. **And I further recommend** that Fassi include in the Use and Maintenance manual 170A.22 a recommendation that a spotter should always be available to the operator of the crane.
3. With the aim of increasing awareness about the dangers of working with heavy hydraulic machinery, **I recommend** that WorkSafe issue Safety Alerts on a regular and periodic basis, and not only in response to a fatality; on the dangers of operating hydraulic cranes, including recommendations that a spotter always be available.

4. In the interests of emphasising the importance of avoiding the unsafe understaffing of heavy machinery, **I recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 27 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who designs plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the designer gives the design... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed.'

5. **And I further recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 29 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who manufactures plant who knows... that the plant... is to be used at a workplace must' inter alia 'give adequate information to each person to whom the manufacturer provides the plant... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was manufactured.'

6. **And I further recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of appropriate staffing, or availability of a spotter, to section 30 of the *Occupational Health and Safety Act 2004*, which requires that 'a person who supplies plant who knows... that the plant... is to be used at a workplace... must' inter alia 'give adequate information to each person to whom the supplier supplies the plant... concerning -... any conditions necessary to ensure the plant... is safe and without risks to health if it is used for a purpose for which it was designed, manufactured or supplied.'

7. **In the alternative, I recommend** that the Minister for Finance, who is also responsible for WorkSafe, the Hon Robin Scott MP, consider the need for the Parliament of Victoria to expressly incorporate the requirement of considering appropriate staffing, or availability of a spotter into Part 3.5 of the *Occupational Health and Safety Regulations 2007*, relating to Plant, or Part 3.6 relating to High Risk Work.

FINDINGS

On the evidence available to me, I find that Mr Andrews died in the course of his work in circumstances that were preventable.

I find that TCB Trans Pty Ltd employed Mr Andrews to operate the crane truck in the absence of appropriate training or licensing. In addition, I find that the lack of an appropriately trained spotter to assist Mr Andrews with the crane truck, contributed to the risk of injury in the circumstances surrounding his death.

While not causal to Mr Andrews' death, I find that TCB Trans Pty Ltd did not demonstrate acceptable practices in relation to record keeping or maintenance of the crane truck, particularly in relation to the Electronic Lifting Moment Limiting Device.

And I further find that the absence of Safe Work Method Statements or Job Safety Analyses in relation to the unloading of the semi-trailer on 8 October 2008, was unacceptable on the parts of both TCB Trans Pty Ltd and Buildcorp Commercial Pty Ltd.

In addition, I find that the absence of appropriate traffic management, including the presence of the private black car in the vicinity of the designated unloading area, as well as the unplanned blocking of McCutcheon Street Northcote, demonstrated poor planning and preparation on behalf of Buildcorp Commercial Pty Ltd.

However, ultimately, I find that Mr Andrews' decisions to position himself between the two trucks, to no not fully extend the left stabilising leg of the crane truck as per the manufacturer's instructions, to not request the assistance of another person on site as a 'spotter', to proceed in the absence of a Job Safety Analysis, and to not contact TCB Trans Pty Ltd when the private vehicle was still parked in the street and affected the anticipated method of unloading the semi-trailer, contributed to his own death.

I accept and adopt the medical cause of death as identified by Dr Paul Bedford and find that Gregory Jon Andrews died from multiple crush injuries to the neck and chest in a workplace accident.

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

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

Mrs Renee Bentley-Andrews

Ms Mary Andrews

Victorian WorkCover Authority (WorkSafe)

Mr Steven Zmak, WorkSafe

Moores Legal on behalf of Renee Bentley-Andrews

Wotton Kearney on behalf of Buildcorp Commercial Pty Ltd

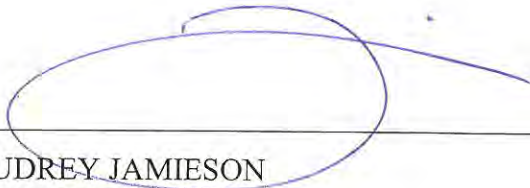
Herbert Geer (now Thomson Geer) on behalf of TCB Trans Pty Ltd

Ambulance Victoria

The Honourable Robin Scott MP, the Victorian Minister for Finance

Senior Constable Trent Barker

Signature:



AUDREY JAMIESON
CORONER

Date: **20 April 2016**