IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2006 1546

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: JOHN RICHARD JONES

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

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

I, AUDREY JAMIESON, Coroner having investigated the death of JOHN RICHARD JONES

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

at Melbourne

find that the identity of the deceased was JOHN RICHARD JONES

born on 16 October 1954

and the death occurred on 28 April 2006

at Mudgegonga, Victoria 3737

from:

1 (a) ELECTROCUTION

in the following summary of circumstances:

1. On 28 April 2006, John Jones was electrocuted whilst acting as a spotter for the driver of a tipper trailer, when the trailer came into contact with overhead power lines while tipping a consignment of lime at Mr Jones' property on Black Flats Road, Mudgegonga, Victoria.

BACKGROUND

2. Mr John Richard Jones, (also known as Jack Jones) was 51 years of age at the time of his death. He lived at Black Flats Road, Mudgegonga, with his partner Ms Lee-Anne Francis. Mr Jones had two sons to a previous marriage aged 17 and 15 years.

3. Mr Jones was a farmer by occupation and ran the small Black Flats Road property.

SURROUNDING CIRCUMSTANCES

4. Mr Jones ordered 37 tonne of agricultural lime from Agricola[3] to be delivered to his Mudgegonga property on 28 April 2006. The delivery was organised by Adelaide Wholesale Landscape Supplies Pty Ltd (AWLS) who assigned employee, Mr Ian McFadyen to make the delivery. Mr McFayden was working alone and this was the first time AWLS had delivered to this site.[4] There was no site visit conducted prior to delivery.

5. Some days prior to 28 April 2006, Mr McFadyen was told to travel to Robe, South Australia, to obtain 37 tonnes of lime from Paul Morgan of Morgan & Howe Pty Ltd. He

[3] Company owning the mining rights; statement of Mr Paul Morgan, 5 May 2011, Inquest Brief.
[4] Statement of Gregory Traeger dated 25 May 2006, Inquest Brief.

was then told to deliver the lime to Mr Jones. Mr McFadyen was provided with Mr Jones' telephone number. No other instructions were provided relating to the delivery.[5]

6. On 28 April 2006, Mr McFadyen drove a Kenworth Bulk Tipper Trailer truck registration XHV 823, towing a 'B' double trailer, registration number ST 5BT[6] to deliver the consignment of lime.

7. Mr Jones directed Mr McFadyen to the paddock where he wanted the delivery unloaded, then indicated to Mr McFadyen the exact location where he wanted the delivery unloaded, which was underneath a Single Wire Earth Return (SWER) power line.[7]

8. There was a discussion between Mr McFadyen and Mr Jones regarding the power line and Mr Jones consequently undertook the role of acting as a lookout/spotter.

9. Mr McFadyen unlocked the rear of trailer and entered the cabin to raise the trailer.[8] The trailer was lifted fully and the load emptied onto the allotted area. Mr Jones was positioned close to the rear of the trailer at this time.

10. Whilst the trailer was still extended, Mr McFadyen drove forward approximately six feet, then checked that all the lime had been dumped. He scraped a bit of remaining lime off the back of the trailer and told Mr Jones to keep an eye out for the power lines while he lowered the trailer. Mr McFadyen then returned to the truck to lower the trailer.[9] He could see Mr Jones in the left mirror at this stage.

11. Mr McFadyen proceeded to lower the trailer. He checked his left mirror and could not see Mr Jones.[10] He was unaware the trailer had contacted the power line while he was lowering the trailer. When Mr McFadyen got out of the truck, he located Mr Jones at the rear of the truck, on the ground. It appeared as though Mr Jones had been electrocuted as a result of trailer contact with the power line.

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[5] Statement of Mr Ian McFadyen dated 19 June 2006, Exhibit 1; statement of Mr Paul Morgan, dated 5 May 2011, Inquest Brief.
[6] Both the Kenworth truck and trailer were registered in South Australia.
[7] See below paragraph 74.
[8] Transcript (T) @ p20, where Mr McFadyen explained that the controls for the tipper are located inside the truck cabin and it is his normal process to tip from inside the truck, however noted that he had access to the controls outside the truck, however as Mr Jones was acting as spotter, he considered it safe to operate the tipper from inside the truck. He stated that he considered it safer for him to tip whilst in the truck (T @ p21). Mr McFadyen stated that there would be no farmer/spotter present on approximately 10% of delivery jobs; T @ p32.
[9] T @ pp24-26.
[10] T @ p41.

12. Ambulance paramedics attended the Black Flats farm and instigated resuscitation measures, however they were unable to revive Mr Jones and he died at the scene.

13. Police also attended at the farm and conducted a preliminary breath test (PBT) on Mr McFadyen that returned a negative result.[11] Mr McFadyn's driver's logbook was examined.[12]

14. WorkSafe investigators and representatives from the power company also attended. Representatives from Energy Safe Victoria (ESV) attended later that evening.

15. The SWER system was identified as one with approximately 12,700 volts passing through the wire. A series of photographs and measurements were taken which identified that:

> *The distance from the front of the semi trailer to the ground was approximately 4.2 metres. At approximately the rear of the trailer, the distance from the ground to the over head wire was 8.7 metres. The nearest power pole was approximately 69 metres away. Approximately 3.06 metres from the front of the trailer, the wire passed over the trailer on the passenger side. The wire was measured at 8.51 metres from the ground. At a point on the driver's side of the truck, near the sleeper cab the wire measured 8.4 metres from the ground.*[13]

16. The truck and trailer were subsequently removed from underneath the SWER line and the boom on the trailer was fully extended, revealing a distance of 10.4 metres from the highest point on the trailer to the ground.[14]

17. On close inspection of the tipper trailer, small electric arc marks were identified on the front passenger side of the tipper trailer.[15]

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[11] T @ p39 & 45.
[12] T @ p39 & 45.
[13] Exhibit 2 - Statement of Senior Constable (S/C) Jeffrey Kyne from the Wangaratta TMU dated 7 June 2006, Inquest Brief page 15, Exhibit 2.
[14] *Ibid.*
[15] Statement of Mr Simon Brown dated 16 June 2006, Exhibit 8; Statement of Mr Terrance Clement dated 11 July 2006, Exhibit 3, Inquest brief page 26. Mr Clement explained that this mark indicated that the live overhead electric line has contacted the truck trailer at these points, thus causing the metallic body of the trailer to also become electrically live.

JURISDICTION

18. At the time of Mr Jones' death, the Coroners Act 1985 (Vic) (the old Act) applied. From 1 November 2009, the Coroners Act 2008 (Vic) (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[16]

19. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety is found in other sections of the new Act.[17]

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

21. Section 67 of the new Act describes the ambit of the Coroner's Findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[18] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

22. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[19] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[20]

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

INVESTIGATION

Identification

23. The identity of John Richard Jones was without dispute and required no additional investigation.

Medical Investigation

24. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a post mortem examination upon the body of Mr Jones. Dr Lynch also reviewed the Form 38 Police Report of Death. Anatomical findings included injuries to the left thumb, ring and middle fingers with microscopic features typical of electrical burns. An incidental finding of coronary artery atherosclerosis was noted.

25. Dr Lynch explained that according to the circumstances, it appeared that Mr Jones' left hand has come into contact with the truck. Toxicological analysis of post mortem blood samples returned negative results for alcohol, and other drugs or poisons.

26. Dr Lynch ascribed the cause of Mr Jones' death to electrocution.

Police Investigation

27. The circumstances of Mr Jones' death were the subject of investigation by Victoria Police on behalf of the Coroner.

28. The Coronial/Inquest brief was prepared by Detective Senior Constable (D/S/C) Paul Campbell from Wangaratta Crime Investigation Unit (CIU). Statements were obtained from Mr Jones' partner, Ms Lee-Anne Francis, Mr McFadyen, attending Paramedics, Wangaratta Traffic Management Unit Senior Constable Jeffrey Kyne, WorkSafe Inspectors Mr Simon Brown and Mr Alan Darwin, ESV Compliance Officer Mr Terence Clement, AWLS Director Mr Gregory Traeger, and Morgan & Howe Partner Mr Paul Morgan. An ESV Electrical Fatality Investigation Report (the ESV Report) dated 10 July 2006[21] was also obtained.

[21] Exhibit 4.

ESV Report

29. Section 7(f) of the *Electricity Safety Act 1999* (Vic) enables ESV to investigate events or incidents that involve electrical safety. ESV participated with WorkSafe in investigating Mr Jones' death. ESV Compliance Officer Mr Terence Clement attended the incident scene and compiled a Fatal Electrical Incident Report dated 10 July 2006 (the ESV Report).[22]

30. The ESV Report, based on the onsite investigation conducted on 28 April 2006, determined that the prime mover with the tipper trailer had contacted a SWER overhead electrical line operating at 12,700 volts ac with respect to earth.

31. The ESV Report noted that SP Aus Net, the local electrical distribution company, advised that the electrical protection provided on the SWER system did not operate on the day of the incident.[23] The ESV Report however stated even if the electrical protection equipment provided on the electrical system had been operating, it is not designed to operate in a manner that will protect a person in contact with the line from electrocution. [24]

32. The ESV Report determined that a person who is in contact with the ground touches conductive components of a trailer that was in contact with an energised overhead electric line would be subjected to an electric current that could cause death.[25]

33. The ESV Report noted that the overhead SWER line measured on the day of the incident complied with the minimum height aboveground required by the *Electrical Safety (Network Assets) Regulations 1999* (Vic).[26]

34. The ESV Report cited the following contributing factors to the incident:

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

    b. placement of the truck and tipper trailer underneath an energised overhead electrical line;

[22] Exhibit 4.
[23] Exhibit 4, p2.
[24] Exhibit 4, p5.
[25] Exhibit 4, p2.
[26] Exhibit 4, p5. These regulations require the minimum height of a SWER line above ground traversable by vehicles to be 5500mm.

c. the size of many tipper trailers currently used is such that when elevated to their maximum height, they will exceed the height that SWER lines are installed above ground; and

d. not being able to accurately estimate the closeness of the tipper trailer to the overhead electric line when viewing from a position on the ground, at the rear left side of the trailer.[27]

35. ESV provided a media release dated 28 April 2006, titled *Safety Regulator Investigates Latest Farm Death*. Mr Ken Gardner, Director of ESV noted in the media release that Mr Jones' death signified the third death in 2006 caused by machinery and equipment touching overhead power lines in rural properties. Mr Gardner referred to the "Look Up and Live"[28] campaign and explained that television commercials warning of the danger of overhead power lines on farms were broadcast throughout regional Victoria over a number of weeks in 2005 and again early in 2006. At the date of the media release, ESV were about to conduct a large scale "Look Up And Live" radio campaign across regional Victoria.

36. ESV laid charges against Mr McFadyen in the Wangaratta Magistrates' Court under the *Electrical Safety (Network Assets) Regulations 1999* (Vic) for coming too close to the power lines. Mr McFadyen pled guilty to the charges and was fined $1,000.[29]

WorkSafe Investigation

37. WorkSafe provided an Entry Report dated 28 April 2006 completed by Mr Brown.

38. WorkSafe Inspector Mr Darwin explained that as there was no employer/employee relationship relating to Mr Jones, there was no breach of the *Occupational Health and Safety Act 2004* (Vic) (OH&S Act),[30] and consequently WorkSafe did not prosecute AWLS.

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[27] Exhibit 4, p5.

[28] A safety campaign undertaken by Energy Safe Victoria, which dates back to 1995 (see *Office of the Chief Electrical Inspector Annual Report 1995/1996*, p 7)and provides information and publications directed at truck drivers, rural property owners and their families about the risks of electrocution from trucks contacting power lines on rural properties. The publications are prefaced with the phrase: "LOOK UP AND LIVE – BE ALERT, BE AWARE – OVERHEAD POWERLINES ARE ALWAYS THERE." (Exhibit 4). This campaign had commenced prior to these deaths.

[29] T @ p34; pp41-42. Mr Murphy on behalf of ESV explained Mr McFadyen also paid costs, and that the maximum penalty at the time was 20 penalty units, each unit being approximately $112 at the time. Mr Murphy explained that the regulations' provision focus on the person operating the relevant equipment, that their jurisdiction does not extend to employers.

[30] Statement of Mr Alan Darwin dated 28 April 2006, Inquest Brief.

SafeWork South Australia similarly did bring proceedings against Mr McFadyen's employer.[31]

Other deaths

39. In 2006, two other men lost their lives in circumstances similar to those surrounding Mr Jones' death. On 9 January 2006, Mr Dallas Anderson died from electrocution whilst tipping a consignment of lime at a farm in Bena, when the trailer of his truck came into contact with overhead power lines.[32] On 19 April 2006, truck driver Mr Brian Baker died whilst delivering fertiliser to a property in Woorak West.[33] The deaths of Dallas Anderson and Brian Baker were also investigated by WorkSafe. In Mr Baker's case, a decision was made not to proceed with a prosecution, however Improvement Notices were issued to Mr Baker's employer and the relevant farmer. In Mr Anderson's case, a prosecution was authorised and charges laid against the supplier and distributor of lime for breaches of the OH&S Act.[34] The matter proceeded to trial in the County Court of Victoria. On 24 June of 2010, the trial jury delivered verdicts of not guilty on all charges in respect of each of the defendant companies.

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

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

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

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

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

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

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[31] T @ pp42 – 43 & 53.
[32] COR 2006 0101.
[33] COR 2006 1427.
[34] The charges against Rodnmar Pty Ltd formerly trading as Korumburra Lime And Spreading and Calcimo Lime & Fertilizers Pty Ltd included:

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

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

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

INQUEST

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

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

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

***Viva voce* evidence at Inquest**

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

a. Mr Ian McFadyen, semi-trailer driver for AWLS;

b. Sergeant Jeffrey Kyne;

c. Mr Terence Clement, Compliance Officer with ESV;[36]

d. Mr Simon Brown – WorkSafe Inspector; and

e. Detective Senior Constable Paul Campbell, Wangaratta CIU.

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

[36] Mr Clement held this position as at 2006. He currently works as an Electrical Industrial Consultant; T @ p53.

Issues investigated at Inquest

45. At the opening of the Inquest into the three deaths, Leading Senior Constable (L/S/C) Antolini, Assisting the Coroner, noted the common threads linking the incidents included the points outlined above in paragraph 40.

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

    a. the order taking method/procedure;

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

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

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

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

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

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

    h. the use of appropriately qualified spotters.

The incident

47. Sergeant Kyne confirmed that neither alcohol nor Mr McFadyen's driving hours were an issue.[37]

48. Sergeant Kyne considered, from viewing the incident scene and his discussions at the time with Mr McFadyen, that Mr Jones had been holding on to the tipper's barn door when the incident occurred.[38]

49. Mr Clement explained that the protection equipment referred to as not functioning on 28 April 2006 consisted of an expulsion/dropout fuse (also referred to as an EDO), which is used to protect the electrical system, not a person.[39] Mr Clement agreed that even if the fuses had been operational on the day, if someone was touching a power line, it would still be a fatal situation, as the amperage capable of fatally passing through the human body is in the

[37] T@ p47.
[38] T @ p49.
[39] T @ p55.

thousandths of amps, a milliamp, whereas the fuse operates at a (nominal) 10 amps.[40] Mr Clement later explained he had mistakenly identified an expulsion fuse, however it was actually an over current relay (OCR) device, which is operated electrically, and monitors how much current is going through the system. It has a predetermined level which, when the system surpasses, automatically trips the system and turns the lines off.[41] Mr Clement however stated that the predetermined level may not be such that this incident may have caused it to trip.[42] Mr Clement was unable to explain whether it was appropriate for this type of line not to have an expulsion fuse/EDO.[43] Mr Clement further explained that neither device would have protected Mr Jones (or Mr Baker).[44]

50. Mr Clement agreed with Sergeant Kyne's suggestion that Mr Jones was touching the truck, stating "I think that would be a reasonable explanation of the...mark on his hand and I think he has been electrocuted, I think he would've been touching the truck somewhere". [45] Mr Clement did not consider it higher than "a very minimal possibility" that the current could have passed through Mr Jones in the absence of him touching the truck.[46]

51. Mr Brown confirmed that his observations of an arc mark identified on the front passenger side of the tipper trailer indicated that the trailer had made contact with the overhead power line.[47]

52. Mr Brown relayed that based on his discussions with Mr McFadyen, it appears that Mr Jones chose for the lime to be dumped at that particular location in his property because he intended to construct an electrical fence around the lime, and the location was close to an existing shed, which was already supplied with power. Mr Brown considered that, if accurate, Mr Jones opted for convenience over safety.[48]

[40] T @ pp58-59.
[41] T @ pp 56 &72.
[42] T @ pp56 & 72.
[43] T @ 72.
[44] T @ p74.
[45] T @ p63, L11.
[46] T @ p63, L21.
[47] T @ p80.
[48] T @ pp90-91.

Mr McFadyen's training and knowledge

53. Mr McFadyen had driven a semi trailer with AWLS for six years and usually drives a 604 Kenworth truck, and performs pick ups and deliveries of bulk supplies of landscape materials within South Australia and interstate.[49]

54. Mr McFadyen had received induction training from Mr Greg Traegar upon commencement of his employment at AWLS. The induction training included familiarisation with the contents of the Operator's Manual, a copy of which was provided to him. Mr McFadyen recalled signing an acknowledgement that he understood the manual's content. A copy of the Operator's Manual is kept within the truck. Mr McFadyen states that he is specifically aware of the provisions in section 8 of the manual, "Tipping", which deals with overhead power lines.[50] The Operator's Manual states:

> "[c]heck for overhead obstructions. If tipping near an overhead obstruction (eg trees, shed, roofs, verandas, telecommunication and power lines), get an outside person (if possible) for guidance to help unload safely. Be sure that the person assisting allows a safe distance between the obstruction and the vehicle and the person is well clear of the vehicle at all times".[51]

55. Mr McFadyen stated he always looks up before tipping the trailer.[52] He stated that a qualified spotter was not provided/available for jobs and that farmers acted as spotters if he was dumping near a power line.[53]

56. When asked what training he had received to assist with awareness of the minimum safe distances that must be maintained between the delivery vehicle and the live SWER wires, Mr McFadyen stated that there was no minimum distance relayed to him in this context, that rather a general awareness of power lines is encouraged.[54] Mr McFadyen stated that basic training is provided in respect of acting as a spotter, including being aware of your

[49] Statement of Mr Ian McFadyen dated 19 June 2006, Exhibit 1
[50] Statement of Mr Ian McFadyen dated 19 June 2006, Exhibit 1.
[51] Statement of Gregory Traeger dated 25 May 2006, Inquest Brief. Operator's Manual, page 15.
[52] T @ p13.
[53] T 2 19.
[54] T @ p33. I note however that Mr McFadyen is employed in South Australia in this regard.

environment, and looking out for potential hazards including trees, power lines and low eaves. No training is provided in relation to where the spotter should position themselves.[55] Mr McFadyen conceded that his training received from his employer was essentially to use his common sense.[56] He explained that since 2006, he has not received any additional formal training about power lines and other risks associated with tipping, but has read articles on point.[57] There is still no spotter provided for deliveries.[58]

57. Mr McFadyen had been driving for approximately 35 years and had delivered hundreds of loads with tippers prior to the incident. During this period, he estimated only ten occasions where he has had to change an intended dumpsite, due to dangers such as power lines. He stated that he identified these dangers by driving into properties and viewing the possible dangers for himself.[59] He stated that there is no checklist to follow in this regard but considered such a checklist would be a helpful prompt.[60] He also considered the placement of warning signs regarding overhead power lines on entry points to paddocks would be beneficial, especially since some deliveries occur after sundown.[61]

58. Mr McFadyen stated that he was more familiar with the "Look Up and Live" campaign and No Go Zones now then he had been in 2006.[62]

Organisation of delivery

59. In his oral evidence, Mr McFadyen stated that he received instruction regarding the dumpsite location from Mr Jones, not his employer.[63]

60. Mr McFadyen stated that he and Mr Jones identified and briefly discussed the issue of the dumpsite being in close proximity to the power lines, especially becoming a problem when Mr McFadyen had to drive forward a short distance to put the hoist down. It was on that

[55] T @ p34.
[56] T @ p41.
[57] T @ p41.
[58] T @ p43.
[59] T @ pp10-12. Mr McFadyen stated he is not involved in the order taking process, which is handled by the administrative staff. He was provided with Mr Jones' contact details by Morgan and Howell, who took the order, being the supplier of lime, and who then subcontracted it to AWLS; T @ p6.
[60] T @ p29.
[61] T @ pp30-31. Mr McFadyen stated that he had never seen such large signs when entering farm properties, but had observed "Look Up and Live" signs on a few occasions, close to the roads.
[62] T @ p28. Mr McFadyen confirmed there were no safety stickers such as those relating to the "Look Up and Live" campaign placed within the truck; T @ p40.
[63] T @ p6.

basis that the two decided that Mr Jones would act as a spotter. Mr Jones did not appear surprised when Mr McFadyen brought this issue to his attention, rather Mr McFadyen formed an impression that he knew the power line was close to the dumpsite and thought that the delivery would be possible at that location.[64] Mr McFadyen stated that although there was not a formal plan in place as to what would occur should the tipper be in danger of contacting the power lines, Mr McFadyen assumed that Mr Jones would "give us a yell if there was going to be a problem being close to the power lines."[65]

61. Mr McFadyen stated that he suggested tipping the second load of lime near where he had tipped the first load (away from the power lines), however Mr Jones communicated that he preferred, although not insisted, it be dumped where he intended on spreading it out (close to the power lines).[66] Mr McFadyen stated that although a load of lime had been previously tipped in the same dumpsite (by another party), the truck that tipped that load would have had a shorter tipper, thus allowing ample clearance from the power lines.[67]

62. Mr McFadyen stated that Mr Jones was positioned approximately one metre away from the vehicle when carrying on his spotting duties.[68] He said that in hindsight, Mr Jones should have been positioned further forward near the truck cabin, with better vision of what was happening.[69]

63. Mr McFadyen explained that when the tipper had reached its fully extended position, it was already higher than the power line seen in the paddock.[70]

Suggested changes

64. Mr McFadyen agreed that a remote controlled tipper control would enable a driver to move away from the tipper (should anything happen to the truck or trailer, the driver would be clear of danger), have a view of the tipping and be able to stop if a problem was encountered.[71]

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[64] T @ pp7-9.
[65] T @ p 27, L2.
[66] T @ pp9-10.
[67] T @ p7.
[68] T @ p34.
[69] T @ p34.
[70] T @ pp37-38.
[71] T @ p22.

65. Mr Clement referred to available devices capable of detecting live wires and capable of remotely operating tippers.[72] Mr Clement supported the suggestions of warning signage at points of farm access and egress, farmer provision of mud maps and communicating known hazards on dockets provided to drivers prior to delivery.[73]

66. Mr Brown agreed with the suggestion of farmers being required to provide mud maps when contractors attend their properties, and further noted that farmers have obligations under the OH&S Act to ensure their safety.[74] He also agreed with the suggestions of farmers being required to fix signs to gateposts alerting visitors to the presence of overhead power lines, and truck companies having checklists requiring their drivers to turn their minds to various safety issues.

67. Sergeant Kyne similarly considered there would be benefit to signage being placed in relation to overhead power lines at points of access and egress.[75]

68. Although D/S/C Campbell agreed in principal with the suggestion of placing warning signs regarding overhead power lines at farm access/egress points, he commented on the possible practical limitations of this suggestion in relation to large properties, stated "[t]here'd be signs everywhere. I don't know if that would be – logistically [possible] to do it on every paddock",[76] however suggested it could be possible if placed at the front of the property.[77] D/S/C agreed that the suggestion of a driver checklist.[78]

Education and general attitudes

69. Mr Brown noted aspects of WorkSafe's preventative work relevant to rural properties across different business sectors. When asked to describe the general attitudes of property owners in rural districts, and their interest in safe work practices in respect of electricity, Mr Brown stated "...generally across the board farmers tend to have a degree of complacency to OH&S...[t]hey're more focused on production..."[79] and ".. I suppose because they work

[72] T @ pp78-79.
[73] T @ p76.
[74] T @ p84.
[75] T @ p52.
[76] T a p94 L25.
[77] T @ p94.
[78] T @ p95.
[79] T @ p82 L 23.

around it all the time and it's a constant for them that they don't perceive that there's the level of risk involved with it".[80]

70. D/S/C Campbell, having worked in the Wangaratta area since 1994, agreed with Mr Brown regarding a general complacent attitude amongst farmers.[81]

Submissions

71. Closing submissions in relation to all three inquests were heard on 28 June 2011. Counsels acting on behalf of the Interested Parties and Counsel Assisting the Coroner provided final submissions, which I have considered for the purpose of this Finding.

General observations of the themes emerging in the three deaths

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

Overhead power lines

73. Mr Jones' and Mr Baker's cases involved a single 12,700 SWER line. In Mr Anderson's case there were two overhead power lines called a 'two-phase 22,000 volts system' that according to Mr Michael Leahy from ESV involves "22,000 volts going out to a transformer and then returning through the other conductor". The difference in the SWER line according to Mr Leahy is that "12,700 volts that return through the conductor, down through the transformer and then return through the ground itself".[82]

74. According to Mr Terence Clement from ESV, the SWER line is a common way of distributing electricity throughout rural Victoria because it is more economical to install than other systems. The SWER line consists of three bare strands of wound steel wire that enables it to be strung for longer distances between poles because it can be pulled very tight. Mr Clement states that the SWER lines are *"rendered safe by installing them at a height that makes them hard to access"* [83] however the bare wires are live and are only protected by an Expulsion Dropout Fuse or EDO.

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[80] T @ p83 L25.
[81] T @ p92.
[82] Inquest into the death of Dallas Anderson, T @ p109.
[83] In the inquest into the death of Brian Baker, Mr Clement noted that it was probable that the SWER line had been installed during 1965 and that the size of many of the tipper trailers in use today is such that when elevated to their maximum height, they will exceed the height that the SWER lines are installed above ground (Investigation into the death of Brian Baker, Exhibit 7, ESV Electrical Safety Investigation Report dated 28 June 2006).

Procedures around taking orders for bulk deliveries, including site inspections

75. Counsel Assisting submitted that there should be definitive procedures in place by companies taking bulk orders for farm supplies. These procedures should include an obligation on their part to ask the farmer/property owner about site hazards and if a safety assessment of the site has been done. Accepting the order and agreement to delivery should be contingent on the safety assessment having been undertaken by the farmer/property owner. In addition and where possible, farmers/property owners should be required to provide maps of their properties to the supplier that identifies hazards such as power lines and dams. The provision of property maps would enable the supplier to carry out their own safety assessment and in the absence of a map, a site inspection should be undertaken by the supplier with the emphasis on identifying safety issues for the driver, which should be ranked above the customer's preferences.[84]

Use of pre-delivery information

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

Knowledge of No Go Zones

77. There was a general lack of knowledge of the minimum distance tipper trucks ought to be away from power lines in order to operate safely. There were general instructions to stay away from power lines but these three deaths have demonstrated that having only basic knowledge and instructions is insufficient for delivery drivers working alone and does not enable them to make proper assessments and identify risks.

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

78. There was and remains no mandatory education about the risks of driving and/or unloading near overhead power lines. Counsel assisting submitted that such education should form part of the endorsed heavy vehicle licence training requirements.[85]

Use of appropriately qualified spotters

79. In each of the deaths, the farmer or property owner acted as a spotter for the delivery driver when they were not appropriately qualified to do so. Where a tipper driver is required to make a delivery in close proximity to power lines, common sense dictates they ought to be accompanied and directed by a qualified spotter. In the Inquest into the death of Dallas Anderson, Mr Stephen Hibberson, sales representative at Calcimo Lime & Fertilizer Pty Ltd acknowledged that a second person might be beneficial for drivers, however might not be economically practical for employers in most tipping jobs. Similarly, coordinating the attendance of, for example, the spreader at the same time as the delivery was not always practical or achievable. He said that "you wouldn't send a spotter out unless there's a particular problem".[86]

Other safety measures

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

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

    b. the use of a job safety analysis on the delivery docket, requiring the driver and customer to sign off on before unloading the ordered farming supplies. This would ensure that both the driver and customer are turning their minds to the risks contemporaneously to the unloading process;

    c. general safety campaigns targeting rural communities; and

[85] Inquest into the death of Dallas Anderson, T @ p330.
[86] Inquest into the death of Dallas Anderson, T @ p69.

d. placing overhead power line warning stickers inside trucks to provide constant reminder of the risks to drivers.[87]

Occupational Health and Safety responsibilities of employers

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

82. It is the role of WorkSafe to provide guidance on how the duties of employers are to be met. In these matters, WorkSafe demonstrated their execution of this role through the material tendered to the Court through witness Mr Bruce Gibson.[88]

83. Mr Goetz submitted that:

> .. *in conjunction with the plethora of written and audiovisual material emphasising the need to look up and live and work at safe distance*[s] *or set distances from power lines, a warning sign on a farm access gate (sic), a safety checklist incorporated into a delivery invoice, a verbal directive to look up, could all indeed be appropriate recommendations arising out of these inquests.*[89]

84. In Mr Murphy's submissions on behalf of ESV he said that it is everybody's responsibility to warn others of the danger of overhead power lines.[90] There is a chain of responsibility commencing with the person placing the order to advise of the presence of power lines proximate to the drop off site and to advise the order taker of any other feature relevant to the power lines. Second, the person receiving the order should question the customer regarding power lines in the vicinity of the drop site. Such information should be included on the delivery docket to alert the driver. Finally, a driver should orient themselves upon arriving at the site to the lines and the adjacent areas to the drop off zone, even though the driver has already received warnings about the area.[91]

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[87] Inquest into the death of Dallas Anderson, T @ p330.
[88] Inquest into the death of Dallas Anderson, Exhibit 18 – Statement of Bruce Gibson and attachments dated 9 May 2011.
[89] Inquest into the death of Dallas Anderson, T @ p337.
[90] Inquest into the death of Dallas Anderson, T @ p345.
[91] Inquest into the death of Dallas Anderson, T @ pp344-345.

De-energising power lines

85. De-energising power lines for the purposes of accommodating the delivery of farming supplies was raised as a possible risk minimisation strategy by witnesses Mr Clement and Mr Ferguson during the course of the Inquest into the death of Brian Baker. De-energising of power lines requires an additional level of pre-planning by the farmer/landowner, involving arranging a qualified electricity work crew to be on-site to de-energise the line at or about the time of the delivery and available on-site to re-energise the line once the delivery is complete and risk of contact with power lines removed. To adopt such a course for the purposes of the delivery of farming supplies, the farmer/landowner must also consider the inconvenience of the interruption of the power supply not only to their own farm but possibly to adjoining farms as according to Mr Ray QC on behalf of Powercor,[92] *"de-energising ordinarily doesn't isolate simply one farm it may isolate instant areas."*[93]

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

Placing power lines underground

87. The issue of replacing rural power lines underground was not a focus of my investigation. At the time of the Inquests I was aware that the *Power line Bushfire Safety Taskforce*[94] was underway. Any inquiries of my own into the feasibility of placing power lines underground would have arguably been a duplication of inquiries and investigations contrary to section 7 of the new Act. Nevertheless, it was appropriate of Mr Murphy to address me on the issue.[95] Three deaths from contact with overhead power lines in rural Victoria in one year necessitates at the very least an acknowledgement that many have advocated for the placing of all power lines underground particularly following the identification of the involvement of overhead power lines in the 7 February 2009 Victorian "Black Saturday" bushfires that claimed 173

[92] Mr Ray QC appeared on behalf of Powercor, who was an Interested Party in the Inquest into the death of Mr Brian Baker. Mr Ray QC also appeared on behalf of Powercor for the purpose of providing submissions at the conclusion of all three Inquests.
[93] Inquest into the death of Dallas Anderson, T @ p360.
[94] The Power line Bushfire Taskforce (the taskforce) was established in August 2010 to consider how the Victorian Government should implement the recommendations of the 2009 Victorian Bushfire Royal Commission.
[95] Inquest into the death of Dallas Anderson, T @ pp345- 347.

Victorian lives. The 2009 Victorian Bushfires Royal Commission concluded that five of the major fires that it investigated were started by power lines. In its July 2010 Final Report, the Royal Commission concluded that:

> *The SWER and 22kV distribution networks constitute a high risk for bushfire ignition, along with other risks posed by the ageing of parts of the networks and the particular limitations of SWER lines.*[96]

88. The Royal Commission made 67 recommendations, of which eight (Recommendations 27 – 34) relate to reducing the likelihood of power lines starting catastrophic bushfires. The Victorian Government accepted all of these recommendations. The *Power line Bushfire Safety Taskforce* (the Taskforce) was established to recommend to the Victorian Government how to maximise the value from the two electricity-related recommendations to Victorians – that is, recommendations 27, which related to power line replacement and recommendation 32, which related to disabling or adjustment of power line reclose functions on the automatic circuit reclosers on all SWER lines for the six weeks of greatest bushfire risk in every fire season. The Taskforce's Final Report[97] was published on 30 September 2011 and acknowledges the risk of bushfires could be reduced by placing power lines underground, however considers the cost of undertaking such a project to be prohibitive. Conversion to an underground rural network, would also function to prevent like deaths to those of Mr Jones, Mr Baker and Mr Anderson however, I defer to the findings of the taskforce that such a project would be financially prohibitive. Accordingly I make no further comment or recommendation regarding placing power lines underground.

Enhancing truck driver awareness

89. VicRoads was not an Interested Party to these proceedings so I do not propose to make formal recommendations with respect to how to enhance truck driver awareness at the time of obtaining a licence. Nevertheless, I did receive sufficient information during the course of these Inquests to form the view that consideration should be given to incorporating into the heavy vehicle knowledge test a section on the *No Go Zones* in all applications for a heavy

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

vehicle licence. Counsel Assisting identified shortcomings in the licence training requirements and made suggestions for improvements. He submitted that:

> *..delivery drivers should be made aware of the safe minimum working distance from power lines and in my view, if the drop off site is in close proximity to the power lines but outside the 6.4 metre spotter zone, then this distance should be clearly identified with markers.*[98]

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

Framework promoting safety

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

Public education and awareness initiatives

92. WorkSafe outlined their agricultural safety program[99] comprising agricultural field days, an advisory service, routine visits by inspectors, agricultural conferences and distribution of guidance material through rural and regional Victoria. In addition, WorkSafe officers distribute ESV resources such as the "Look Up, Look Down and Live" DVD and vehicle stickers, to owners of rural properties. Both organisations also have had and continue to have an abundance of safety information on their websites.

93. I accept that there is indeed an abundance of occupational health and safety information and support available to the farming and agricultural sector which is readily accessible to them. I also accept that Powercor annually undertakes a mail out to all owners of private overhead electric lines, enclosing a brochure which contains information reminding owners of their inspection and maintenance obligations, to plan farm roads for tall equipment so they do not

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

pass under electricity lines as well as other electrical safety information.[100] The distribution of this information from the electricity provider is currently in the vicinity of 26,000 landowners/occupiers of land.[101]

94. I accept that there is a collaborative approach between WorkSafe and ESV to safety education and I further accept and acknowledge that a considerable amount of work has been done in this area before these three fatalities and continues to be done since the deaths. The power companies also play a role. The challenge particularly for ESV and WorkSafe is in effectively educating farmers of the dangers of electricity on farms and "getting the message across on safety".[102] Farming is not a concentrated industry such as the construction industry whose participants might acknowledge the existence of like occupational health and safety issues. Farming and associated businesses working within the agricultural sector appear to be a disparate group with disparate views. Assuming the witnesses I heard from in these Inquests are generally reflective of the views of the agricultural sector, I would consequently assume there is also a general antipathy or resistance to change. Any antipathy to acknowledging risks and genuinely considering implementing measures to improve safety is unfortunate and yet another hurdle for WorkSafe and ESV.

Height detection devices

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

96. ESV contributed some funding[103] to a private business for the development of a height detection device that omits an audible sound upon detection of an electrical field within a calibrated height but this particular device does not have the capacity to shut off hydraulics or engines when it is detected. The development of this device was last reported to making slow

[100] Inquest into the death of Dallas Anderson, T @ pp204-205.
[101] Inquest into the death of Dallas Anderson, T @ p205.
[102] Inquest into the death of Dallas Anderson, T @ p112.
[103] Inquest into the death of Dallas Anderson, T @ p295.

progress and not performing as expected.[104] In his closing submissions, Mr Murphy on behalf of ESV confirmed that no height detection devices had been fitted to tipper trailers and he indicated that a limitation on all height detection devices is that they rely on the operator resetting the device on every occasion.[105] Mr Walters gave the same indication when speaking of one such device, "ProxyVolt®",[106] a product whose use appears to be confined to plant in the mining industry.[107] He said that he thought they were more suited to plant that is set up in an established place of work/controlled environment whereas a truck may only visit a site with a particular above height risk once and would likely encounter a different height risk at the next delivery site.[108] Such is the scenario for contractors delivering large volume farming products to different farms and the need to reset the voltage detection device on each occasion could be cumbersome for the drivers.

97. The evidence indicates that there are a number of impediments to high voltage proximity warning systems being embraced in the heavy transport sector. One of those impediments appears to be lack of product development. Wilsave power line detectors[109] had not gone into production at the time of these Inquests, Sigalarm™ was a product not available in Australia and ProxyVolt® was being used in a restricted capacity in the mining industry only and had not been developed to attach to the hydraulic systems such as used in tipper trailers (according to Mr Walters).[110] ProxyVolt® report that their product is capable of being applied to tipper trucks but that it does require recalibration of the device for each location.

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

FINDINGS

1. I find the identity of the deceased is John Richard Jones (also known as Jack Jones).

2. I accept and adopt the medical cause of death as ascribed by Dr Matthew Lynch and find that John Richard Jones died from electrocution from high voltage electricity wires in

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

circumstances where a tipper trailer contacted overhead transmission lines on his farming property while he was acting as spotter in the unloading process.

3. AND the weight of evidence supports a finding that Mr Jones' left hand was touching the rear of the tipper trailer at the time of the contact with the overhead lines and indicates that he was inappropriately positioned at the time he was acting as a spotter.

4. AND I further find that the death of John Richard Jones was avoidable and preventable.

CONCLUDING COMMENTS:

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

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

The entirety of the process from the farmer/property owner placing an order to delivery by the employee/contractor truck driver necessitates that risk minimisation is front and foremost in each and every participant's mind. The process clearly starts with the farmer/property owner who requires the supply of materials and has the most intimate knowledge of their property that, if conveyed accurately, can minimise risk and indeed prevent harms. It is the farmer/property owner that knows the layout of their land, knows where overhead power lines are situated and has the time either before placing the order or between placing the order and delivery to identify and prepare a safe delivery site. Mrs Alecia Anderson[111] suggested that consideration should be given to the implementation of a farm safety accreditation program through Farmsafe or WorkSafe and that a levy could be charged to farmers who did not go through accreditation, creating a pool of money that could be put back into training and safety programs. She also suggested that as part of such an accreditation program, farmers could seek certification for a nominated dumpsite. Mrs Anderson's vision for the future was that companies would not deliver to a site that had not been certified as safe. Mr Ray QC supported Mrs Anderson's suggestion for certified dumpsites which he described as:

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

..a practical farm person's recognition of ensuring that the locality is safe and free of the over head hazard.[112]

In the absence of the identification of risks by the farmer/property owner, communication of the same and preparation prior to the arrival of the delivery, all risk minimisation responsibility transfers to the driver. The offer by a farmer/property owner to clear a different site or move some other structure to provide a safer site at this point in the process unnecessarily creates decision-making and time impost on the driver. The driver cannot and should not divest themselves of the risk minimisation responsibility, but such an impost seems inequitable when the farmer/property owner starts from a greater knowledge base and as such is at the head of *the hierarchy of risk management where the first thing you do is engineer out the risk.*[113]

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

In 2009 the Coroners Prevention Unit (CPU)[114] analysed ESV's data on the number of mobile plant contacts with power lines and this demonstrated that between 2002 and 2009, 101 tippertrucks contacted power lines in Victoria which represents an average of one contact incident per month. Tipper trucks accounted for 15% (n=16) of all contact incidents reported to ESV in a one-year period (July 2008- June 2009). The analyses of the data indicated that at that time the "Look Up and

[112] Inquest into the death of Dallas Anderson, T @ p354.
[113] Inquest into the death of Dallas Anderson, T @ p355.
[114] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

Live" awareness campaigns and mandatory minimum clearance distances established by WorkSafe and ESV had not demonstrated a reduction in the number of mobile plant contacts with power lines.

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

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

RECOMMENDATIONS:

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

I commend the submissions for the improvement to order forms to include a checklist with details of overhead power lines, the signing of the Order Form by both driver and farmer/property owner prior to unloading and farmers providing a mud map to the supplier for the driver's use. These submissions however are arguably all directed at improving the consciousness of individual farmers/property owners and distinct businesses. There were no submissions made by the interested parties as to whom I could direct these broad risk minimisation recommendations. As far as I am aware, Order Forms/dockets are neither in a prescribed form nor mandated by any legislation/regulations for private businesses. I could thus only make recommendations to the suppliers the subject of these three investigations which would not achieve the far-reaching preventative outcome arguably envisaged by the submissions. I do not have the jurisdictional scope[115] to make recommendations with respect to the ordering processes that I could expect to reach beyond the three suppliers and result in a uniform approach to this discreet aspect of risk minimisation. Furthermore, I do not have the jurisdictional scope to recommend, for example, that all farmers in Victoria provide a mud map to a supplier before taking delivery of farming supplies or indeed that they and other related employers should inform themselves about the risks associated with working near and contacting overhead power lines. I can merely encourage them to adopt at

[115] *Harmsworth v The State Coroner* [1989] VR 989.

the very least, the risk minimisation strategies that were identified in these Inquests including utilising documents that have been prepared by WorkSafe and contained in their publications to help with these tasks including the "15 Minute Farm Safety Checklist" which has been available since July 2001.[116]

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

I commend WorkSafe and Energy Safe Victoria for their efforts to disseminate information and provide education to rural Victorians on the risks associated with working near and contacting overhead power lines and the Regulations in respect of the same. I support the continuation of such educational forums and where possible, including with reference to the recommendations below, the expansion of educational programs/forums to rural Victorians. Mr Dallas Anderson's mother, Mrs Susanne Anderson, herself a farmer, also expressed her support for the educational measures adopted by WorkSafe and ESV asking of WorkSafe: "*please don't give up*". She said you just have to "*keep batting into farmers*" about safety issues and eventually they will adopt them.[117] However as with all educational programs or campaigns their effectiveness needs periodic evaluation. The evidence in each of these Inquests reflects that the individuals did all look up and were all aware of the overhead power lines yet proceeded in behaviours contrary to the message of the "Look and Live" campaign. Three deaths is a clear indication that, at that time, the message was not being effectively conveyed.

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

1. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, I recommend that WorkSafe in consultation and collaboration with Energy Safe Victoria, Farmsafe Australia Inc, Powercor and other relevant electricity power suppliers, produce signage which alerts a visitor/contractor to the presence and risks of over head power lines on a given property. [118]

[116] Inquest into the death of Dallas Anderson, Exhibit 18 – Statement of Bruce Gibson dated 9 May 2011, T @ p179.
[117] Inquest into the death of Dallas Anderson, T @ p291.
[118] This recommendation recognises that first, there remains a possibility that Mr Dallas Anderson did not see the overhead power line and relevant signage could have alerted him to its presence, secondly, as pointed out in evidence adduced during the Inquest into the death of John Jones, some farm deliveries occur after dark, rendering on site-risk

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

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

4. With the aim of minimising risks associated with contacting overhead power lines on farming and rural properties, and with a view to ongoing compliance with the safety signage program recommended above, I recommend that Farmsafe Australia Inc in consultation and collaboration with WorkSafe develop a farm safety accreditation program as suggested by Alicia Anderson.[119]

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

6. With the aim of minimising contact incidents with overhead power lines by tipper truck trailers, I recommend that WorkSafe and Energy Safe Victoria invest in the evaluation of

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assessments ineffective at identifying the risk of overhead power lines, and thirdly, that similar signage appears to have been widely accepted and effective nationally and internationally in the identification of hazardous chemicals by the use of the 'Hazchem' signs. The recommendation also recognises the evidence of ESV Compliance Officer Mr Terence Clement provided in the inquest into the death of Brian Baker, that rural SWER lines were installed in around 1965, and that the size of many of the tipper trailers currently in use is such that when elevated to their maximum height, they will exceed the height that the SWER lines are installed above ground (see above no 83). This recommendation recognises the impracticality and economic burden associated with changing the entire rural SER network, and rather offers an arguably more economically viable option to help minimise this hazard.

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

proximity warning devices to determine their efficacy, applicability and practicability to tipper trucks.

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

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

- Ms Lee-Ann Francis
- WorkSafe Victoria
- Mr John Murphy on behalf of Energy Safe Victoria
- Powercor Australia Pty Ltd
- Farmsafe Australia Inc
- Transport Workers Union
- Australian Workers Union
- Detective Senior Constable Paul Campbell

Signature:

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