IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3966

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**RICHARD NEIL GAUDION**
Date of birth:	**19 February 1958**
Date of death:	**10 August 2018**
Cause of death:	**Injuries sustained in a motor vehicle incident (driver)**
Place of death:	**Unnamed track at 669 Upper Rose River Road, Rose River Vitoria 3678 (latitude= 36.93312, longitude= 146.52627)**

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

1. Richard Neil Gaudion was 60-years-old at the time of his death.

2. Mr Gaudion worked as a Wild Dog Controller (WDC) for the Department of Environment, Land, Water and Planning (DELWP). Mr Gaudion commenced employment with the Department of Natural Resources and Environment on 6 November 1998 as a Field Services Officer. In December of 2002, Mr Gaudion moved to the Department of Primary Industries in the role of WDC.

3. Under the *Catchment and Land Protection Act 1994* (Vic), DELWP have a responsibility to prevent the spread of established pest animals from both public and private land. The work of a WDC involves liaising with landowners and consulting with the broader community to identify and eradicate wild dogs that are considered detrimental to livestock. WDCs undertake poisoning programs, trapping and shooting to achieve outcomes. To enable WDCs to undertake these tasks, often in remote locations, they are issued with a departmental vehicle fitted with dog boxes, UHF radios, firearms and location devices. WDCs also maintain and utilise trained scent dogs.

4. Mr Gaudion remained in the WDC role throughout the various departmental restructures until 11 August 2018, when he was found deceased in bushland in circumstances that suggest his vehicle had rolled and crushed him.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mr Gaudion, reviewed a post mortem computed tomography (CT) scan, information in the VIFM contact log and referred to the Victoria Police Report of Death, Form 83.

6. Dr Lynch commented that the external examination of Mr Gaudion's body was consistent with the history. The post mortem CT scan revealed a fractured pelvis, bilateral rib fractures, left haemothorax, fractures of lumbar spine transverse processes, no pneumothorax and ruptured right hemidiaphragm.

7. Dr Lynch ascribed the cause of death to injuries sustained in motor vehicle incident (driver).

Police investigation

8. Upon attending the location of the incident after Mr Gaudion's death, Victoria Police found the vehicle on its side with Mr Gaudion's body nearby. The vehicle was on its left side, facing south. The vehicle's keys were in the ignition in the off position. The handbrake was not engaged and the gear lever was in first gear. Investigating officers further noted that the track Mr Gaudion had been traveling along was a fire access/ farm track on a steep sided hill paddock. Local resident and surgeon, Robert Martin, advised Victoria Police that he had assessed Mr Gaudion and was of the view that he was deceased.

9. Sergeant Tim Hart was the nominated Coroner's Investigator.[1] At my direction, Sergeant Hart investigated the circumstances surrounding Mr Gaudion's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, colleagues, witnesses and investigating officers.

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

10. During the investigation, police learned that Mr Gaudion generally worked alone in a four-wheel drive (4WD) supplied by DELWP. The DELWP vehicle supplied to him was a 2017 Toyota Landcruiser 4WD tray with a slip-on pod-storage system (the vehicle) that contained equipment used in his position. He primarily worked in the area known as the Whitefield Management Zone.

11. On 10 August 2018 at approximately 9.35am, Mr Gaudion commenced duties in the Rose River area. He notified his supervisor, David Klippel, of his departure via text message.

12. In his statement to the Coroner's Investigator, Mr Klippel detailed that Mr Gaudion was very good at his job. He was methodical, confident and competent at his duties. He drove at a 'snail's pace' and was observant. Mr Klippel further stated that he had been in the vehicle when Mr Gaudion was required to negotiate difficult terrain in the bush both on and off tracks and off road completely. He considered Mr Gaudion to be a careful driver who did not take risks. Mr Gaudion had undertaken 4WD training through his employer in October of 2000, in addition to more recent training (not specific to his vehicle) on safe driving in February 2018.

13. Mr Gaudion was required to notify his employer of his cessation time at the end of each day using his issued DELWP SPOT Gen3 personal satellite communicator (spot-checker). Mr Gaudion would usually send a text message to Mr Klippel instead.

14. Due to Mr Klippel finishing work early on 10 August 2018, he did not receive text notification of Mr Gaudion finishing work that day.

15. On 11 August 2018, Mr Gaudion's partner, Tina Moyle, grew concerned after not being able to contact him. Ms Moyle went over to Mr Gaudion's residence and upon her arrival, concluded that he had not returned from work the previous evening. At 11.15am, Ms Moyle contacted Mr Klippel.

16. Mr Klippel checked Mr Gaudion's spot-checker location via his computer. The spot-checker's position was in a paddock area on Robert Martin's property[2]. It also showed that the spot-checker had been stationary and had not moved since the previous day.

[2] 669 Upper Rose River Road, Rose River Vitoria 3678

17. Mr Klippel contacted his supervisor, Tim Enshaw, and advised of his concerns. Shortly afterwards, Mr Klippel commenced the drive to the location identified by the spot-checker. As he was travelling towards the location, Mr Klippel received a phone call from Rose River resident and farmer, Matthew Roberts. Mr Roberts advised that he had seen something in a paddock when he was driving along Upper Rose River Road between 7.30am and 8.00am that morning but that due to poor visibility, he thought it was a water tank.

18. Mr Klippel drove to the location at approximately 12.25pm and was met by another local property owner who advised that they had found the vehicle overturned on its side, with the body of Mr Gaudion a short distance away.

19. Emergency services were contacted and arrived a short time later. WorkSafe Victoria (WorkSafe) were also notified. Ambulance Victoria arrived at 1.38pm and confirmed Mr Gaudion was deceased.

20. Subsequent investigations were conducted by Victoria Police and WorkSafe. The reports produced from these investigations favour varying reconstructions of what caused Mr Gaudion's vehicle to roll.

21. Investigations included an assessment of Mr Gaudion's spot-checker by a satellite communications specialist. The device was assessed and determined to be in good working condition. On 10 August 2018, the spot-checker recorded its location a total of 13 times.

22. The spot-checker operated so that it would broadcast its location every ten minutes if the device was moving. When it became idle, at the next ten minute broadcast point, it would broadcast at its stationary location before suspending its tracking until it commenced movement again. The assessment of the spot-checker showed that on 10 August 2018 at 11.24am, a signal was sent for the area of the incident. Ten minutes later, it broadcast the same position. This indicates that the incident most likely occurred between 11.24am and 11.33am.

23. It was noted that the spot-checker broadcast its location six times between 5.02pm and 8.34pm on the same day within an approximate five metre radius. The reason for the device broadcasting again was likely due to it being disturbed by animals, causing the

track function to activate. The discrepancy within the radius was considered due to satellite error.

24. The Collision Reconstruction and Mechanical Investigation Unit (CRMIU) report details that it cannot be determined with certainty why the vehicle rolled. The 4.9 seconds of pre-crash data would have reported an application of accelerator or braking, despite the engine not being on. While it is possible that the vehicle may have stalled more than 4.9 seconds before the incident, if this had been the case it would be expected that Mr Gaudion would have attempted to regain control by applying the brake or accelerator. There was no evidence of any action within the vehicle in the 4.9 seconds prior to the incident and subsequently, no evidence to suggest Mr Gaudion was inside the vehicle at the time of the slide.

25. CRMIU concluded that it was their opinion that Mr Gaudion was not seated in the driver's seat when the vehicle commenced its roll.

26. The CRMIU also inspected the vehicle. This inspection did not reveal any mechanical faults that would have caused or contributed to the incident.

27. WorkSafe came to a different conclusion, instead preferring a reconstruction detailing that Mr Gaudion followed the well compacted and used dirt track for approximately one kilometre before heading in a southerly direction on a dozer track, which followed the tree line at the top of the hill in a southerly direction. He is believed to have followed this track for approximately one kilometre before taking its tight turn in a westerly direction. The gradient on the track was measured to be 32 degrees, upon which Mr Gaudion is thought to have engaged his vehicle.

28. After approximately 18 metres, WorkSafe concluded that Mr Gaudion allowed his vehicle to free-roll in a reverse direction with the clutch fully engaged but the vehicle still in first gear. It is assumed that as the vehicle approached the corner, it skidded to the passenger side and dropped off a 500-600 metre embankment. The vehicle then rolled six times, before coming to a rest on the passenger side, 67 metres from the track.

29. WorkSafe stated that measurements of the scene revealed that Mr Gaudion was ejected from the vehicle on the second revolution, through the driver side window. They detailed that this was confirmed via damage to the window frame and fibres from Mr Gaudion's

jumper. Mr Gaudion's injuries were consistent with the vehicle colliding with him as it rolled. The severity of his injuries indicate that he was killed instantly. WorkSafe also noted that the driver side seatbelt was fully retracted and did not have signs of damage. They viewed this as being consistent with Mr Gaudion not wearing his seatbelt at the time of the incident.

30. In the period leading up to the incident there had been heavier than normal rainfall. Of note was the heavy rainfall in the area in the preceding 36 hours. On 8 August 2018, 15 millimetres of rainfall was recorded and 21.2 millimetres the previous day, 9 August 2018.

31. On inspection of the scene, the ground was noted as being extremely wet and soft underfoot. Several low areas of ground contained large pools of water. The corner from which it is believed Mr Gaudion's vehicle commenced its roll was described by WorkSafe as 'boggy', meaning the corner had taken up and was holding a significant amount of moisture. Moss and wet grass were abundant, making the area extremely slippery, resulting in reduced vehicle traction.

32. I note that it is impossible to determine exactly where Mr Gaudion was located and what he was doing immediately prior to the vehicle commencing its roll. I am however, satisfied to the requisite standard that he has somehow been collected in the vehicle's roll, either by way of being inside of it or standing next to it, and subsequently been crushed in the process of its rotation down the embankment.

COMMENTS

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

1. WorkSafe's investigation identified seven contributing factors in the death of Mr Gaudion. These were as follows:

    a. Mr Gaudion had not undertaken formal 4WD training with DELWP since the year 2000. Subsequently, his skills were not considered to have been current and in line with DELWP practice.

    b. Mr Gaudion was unfamiliar with the location of the accident and had undertaken no documented risk assessment prior to undertaking the task.

    c. Mr Gaudion was not wearing a seatbelt, thereby in breach of DELWP policy, which states that a seatbelt must be worn at all times.

    d. The track was wet and slippery, resulting in lack of traction.

    e. The gradient of the hill was determined to be 32 degrees. DELWP 4WD training recommends a maximum gradient of 25 degrees in dry conditions.

    f. Mr Gaudion used the clutch and brakes to descend backwards down the hill, rather than selecting reverse gears. The technique taught and recommended to reverse downhill involves stalling the vehicle, applying the handbrake, transferring the gear from first to reverse, applying the footbrake, releasing the handbrake and then the footbrake before starting the vehicle and driving down. This technique provides superior control.

2. WorkSafe's investigation resulted in several recommendations.

3. WorkSafe worked alongside DELWP in considering changes to departmental arrangements used to monitor DELWP employees who are required to work alone in remote locations. I will not detail these in full instead, only listing the ones I consider pertinent to the findings of my own investigation.

4. WorkSafe's investigation noted that DELWP Job Safety Planning (JSP) is a documented step by step system of working, which outlines how tasks can be undertaken safely by linking to the relevant Departmental Safe Operating Instructions and Safe Work Procedures. The JSP was discovered to not be widely used in the Wild Dog Program. This included the application of Site Safety Surveys, as detailed at comment [1][a]. WorkSafe recommended that all DELWP staff who work in the field utilise the JSP.

5. WorkSafe recommended that the DELWP mandate 4WD training every five years for staff who use 4WD vehicles as part of their role. Specifically, that DEWLP identify any wild dog controllers who have not received 4WD training within the past five years and ensure they receive training within 12 months.

6. While not a contributing factor, WorkSafe noted that the call-in procedure specified in the Safe Work Procedures was not followed by Mr Gaudion and not effective due to workloads, resourcing issues and lack of mobile and satellite coverage. It was considered that this placed an unreasonable reliance on the personal vigilance of the staff member and manager, who could also be out of mobile/ satellite coverage.

7. It was also noted by WorkSafe that the SPOT trackers used at the time of the incident did not have full coverage across Victoria. It was estimated that 7-15% of areas in which wild dog trackers operate do not have coverage. It was recommended that alterative technologies and call-in mechanisms to enhance staff safety when working in isolation be investigated.

8. WorkSafe recommended that DELWP develop effective and workable call-in and location procedures. While there is no evidence to suggest that the earlier realisation of Mr Gaudion's absence would have saved his life, it would have likely resulted in the earlier discovery of his body.

9. As at 21 March 2019, an action plan was provided to WorkSafe in relation to Mr Gaudion's death. It indicated that 4WD training was provided to employees not in emergency roles that are required to operate 4WD vehicles.

10. As at 21 March 2019, DELWP indicated to WorkSafe that an updated package of policies and procedures was in the process of being implemented. DELWP acknowledged that coverage black spots made it difficult to identify the best options

available for monitoring. It was expected that a range of equipment would be rolled out across DELWP using a risk assessment process identifying the most at risk employees. Training on the new process would be provided.

11. WorkSafe further recommended that Wild Dog Controller Work Reviews be updated and that the Wild Dog Program be reviewed to ensure compliance with governing documentation.

12. As at 21 March 2019, pending finalisation of the above [9], the following interim measures were implemented:

    a. Monitoring by way of a third party 24 hour operator, with employees required to call-in at arranged intervals. Used for most at risk employees, including wild dog controllers.

    b. Teams undertaking tasks in remote areas required to establish a Communications Plan as part of the overall JSP.

    WorkSafe considered these interim controls to be adequate, pending the development and implementation of a DELWP wide process.

FINDINGS

1. I find that Richard Neil Gaudion, born 19 February 1958, died on 10 August 2018 along an unnamed track at 669 Upper Rose River Road, Rose River Vitoria 3678 (latitude= 36.93312, longitude= 146.52627) whilst acting in the course of his employment.

2. I find that WorkSafe and DELWP have worked collaboratively to identify and implement work procedures and training with the aim of improving occupational health and safety for DELWP employees and preventing like deaths.

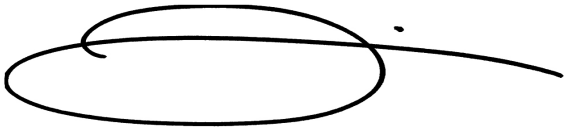
3. I accept and adopt the cause of death ascribed by Dr Matthew Lynch and I find that Richard Neil Gaudion died from injuries sustained in a motor vehicle incident in which he was the driver.

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

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

Sarah Wilkins
Danny Frigerio, solicitor on behalf of Tina Moyle
Robert Shepherd, solicitor on behalf of WorkSafe
Mathew Read, WorkSafe Victoria
Clare Rowan, Transport Accident Commission
Sergeant Tim Hart

Signature:



AUDREY JAMIESON
CORONER
Date**: 5 May 2020**