IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 0607**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**GAVIN LESLIE BOYD**
Date of birth:	**30 SEPTEMBER 1962**
Date of death:	**6 FEBRUARY 2018**
Cause of death:	**ELECTROCUTION**
Place of death:	**KIEWA VALLEY HIGHWAY, KERGUNYAH, VICTORIA 3691**

HIS HONOUR:

BACKGROUND

1. Gavin Leslie Boyd was born on 30 September 1962. He was 55 years old at the time of his death. He lived in Shepparton and was employed by FertGrain as a truck driver.

2. Gavin commenced work with FertGrain in 2003 delivering bulk grain and fertiliser in Victoria and southern New South Wales. According to FertGrain's General Manager, Ashley Quinn, Gavin was a very knowledgeable, experienced and safety-conscious driver. His most recent driver's declaration noted that he had driven trucks for approximately 35 years and completed around 6 million kilometres.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Gavin's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and resulted, directly or indirectly, from an accident or injury.[1]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

---

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008*.
[2] Section 89(4) *Coroners Act 2008*.
[3] *Keown v Khan* (1999) 1 VR 69.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Gavin Leslie Boyd was identified via fingerprint identification on 9 February 2018. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 8 February 2018, Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on Gavin's body and provided a written report dated 20 June 2018, concluding a reasonable cause of death to be "I(a) Electrocution". I accept her opinion in relation to the cause of death.

[4] (1938) 60 CLR 336.

13. Toxicological analysis of post mortem specimens did not detect alcohol, common drugs or poisons.

14. Dr Archer noted there was no significant natural disease that could have caused death by alternative means, and the autopsy findings were consistent with high voltage electrocution.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 6 February 2018, Cherie Mills of Federation Bulk Haulage (**FBH**) received a purchase order to pick up 80 tonnes of Super Phosphate (**Super**) from Geelong and deliver it to a dairy farm located on the Kiewa Valley Highway, Kergunyah. FBH did not receive any information regarding overhead power lines at the delivery site and had not previously been alerted to their presence when completing jobs at this site in the past.

16. FBH subsequently subcontracted this job to FertGrain for delivery, and the job was allocated to Gavin. Gavin was provided with the delivery information and, at approximately 11:44am, he telephoned the dairy farm owner and advised he would be delivering the Super later that day. According to the GPS log data obtained from the truck Gavin was driving, he departed Geelong at 12:37pm and travelled to Kergunyah.

17. In the three years prior to the incident, the dairy farm received bulk deliveries in 'Paddock 1' which was the first paddock from the road on the left-hand side of the entrance driveway. There is irrigation in the middle of the paddock, so deliveries were made near the front fence, away from the irrigation. Paddock 1 is approximately 10 acres in size and there are three-phase overhead power lines which cross the paddock.

18. At approximately 5:23pm, the dairy farm owner returned a missed call from Gavin. He stated he was at the roadworks near 'Waddingtons' and they arranged to meet at the entrance to Paddock 1. The farm owner subsequently met Gavin at the gates and directed him to unload the Super away from a recently unloaded pile of lime. She drew his attention to the irrigation, however, they did not discuss the overhead power lines. The farm owner then drove back up to the dairy.

19. Approximately five minutes later, the owner noticed a loss of power. According to Energy Safe Victoria, an electrical fault was detected at 5:34pm on 6 February 2018. The owner and an employee drove down to Paddock 1 to check on Gavin. When they arrived, they

discovered Gavin's trailer in contact with the overhead power lines and the back left tyre was on fire.

20. On closer inspection, Gavin was discovered unresponsive, lying on the ground near the driver's side of the truck. The dairy farm owner went over to check on Gavin, however, she received a shock before reaching him and moved away. She subsequently contacted emergency services at 5:47pm.

21. The Country Fire Authority, Victoria Police, Ambulance Victoria, State Emergency Services, WorkSafe, Energy Safe Victoria and Ausnet Services attended the property. The CFA attempted to extinguish the fire while Energy Safe and Ausnet isolated the electricity at the site. Assistance could not be rendered to Gavin until the site was made safe, however, he was subsequently confirmed deceased at the scene.

Energy Safe Victoria investigation

22. Energy Safe Victoria conducted an investigation into the fatal electrical incident. The investigation concluded that the front of the trailer contacted the centre and outer conductors of the three-phase 22kV aerial electric line which resulted in an electrical fault. The electrical fault energised the trailer igniting a fire, and flowed to the ground creating a "dangerous step and touch potential".[5]

23. Based on this information, Energy Safe concluded that Gavin suffered a fatal electric shock either due to physically coming into contact with his truck and the ground simultaneously, or by standing near the truck when he exited the vehicle.

24. The investigation also concluded that the trailer was in breach of the 2,000 mm regulatory clearance of the electric line conductors, and that the HV feeder protection devices of the supply network operated as intended.

WorkSafe investigation

25. Victoria Police notified WorkSafe of Gavin's death. WorkSafe inspectors attended the scene and also spoke with FertGrain employees. The driver who had recently delivered the lime to Paddock 1 was also interviewed and confirmed he was not warned about the power lines or the underground irrigation when he attended the property in the days preceding the incident.

[5] This means a person is at risk of injury during a fault simply by standing near the grounding point, or by being in contact with the energised object.

26. During WorkSafe's attendance at the scene, the owners of the dairy farm stated they would cease receiving deliveries at this location and would find an alternate area for deliveries. WorkSafe provided a large reflective sign produced in conjunction with Energy Safe Victoria. It was placed nearby the entry gates and warned of the power lines overhead. The gates were also chained and padlocked shut by the farm owners to prevent access.

27. Following these actions, WorkSafe were satisfied that the prevention of access, the placement of a warning sign, and the requirement for future deliveries to take place at an alternate location sufficiently controlled the risks at this site. Consequently, a safety improvement notice was not issued.

28. In relation to Gavin's employer, FertGrain, their records indicated they had not made previous deliveries to the Kergunyah dairy farm. Mr Quinn stated that FertGrain's procedure was to verbally inform its employees of any electrical safety issues on job sites, such as overhead power lines at a farm. This informal process was confirmed by one of Gavin's colleagues, Mr Graeme Mahncke, who stated that warnings regarding hazards were sometimes provided to him verbally by his manager, and they usually relied on property owners to identify hazards.

29. Mr Quinn noted that since Gavin's death, the business undertook a review of its policies and procedures and the Overhead Power Lines Policy was reviewed. Mr Quinn also noted that:

    (a) instruction on 'No Go Zones' and actions to be taken in the event of contact with power lines was implemented;

    (b) an unloading checklist was developed and implemented with checks for overhead power lines;

    (c) "look up and live" stickers were added to the trucks/trailers; and

    (d) meetings were held on the implementation of the changes.

30. WorkSafe reviewed the Overhead Power Lines Policy and recommended:

    (a) increasing supervision when appropriate site conditions cannot immediately be met;

    (b) questioning the site occupier regarding the presence of overhead power lines; and

    (c) differentiating between stationary and mobile unloading.

31. These recommendations were subsequently met with the addition of the implementation of an induction questionnaire for new employees, including testing which referenced organisational policies and procedures. Ultimately, WorkSafe was satisfied that these improvements met the standards of a safe system of work for unloading of tip trucks' trailers in the vicinity of overhead power lines and no further intervention was required.

32. I am also satisfied that the improvements made by the farm owners and FertGrain in consultation with WorkSafe sufficiently reduce the risk of similar incidents occurring in future.

FINDINGS

33. Having investigated the death of Gavin Leslie Boyd, and having considered all of the available evidence, I am satisfied that no further investigation is required.

34. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Gavin Leslie Boyd, born 30 September 1962;

    (b) that Gavin Leslie Boyd died on 6 February 2018, at a property on the Kiewa Valley Highway, Kergunyah, Victoria, from electrocution; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

RECOMMENDATIONS

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

    (a) WorkSafe distribute an industry-wide release setting out the lessons learnt, and the initiatives undertaken by the employer and the farm owner in this case, in order to reduce the risk of electrocution by overhead power lines.

36. I convey my sincerest sympathy to Gavin's family and friends.

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

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

(a) Gavin's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 31 August 2020