IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004026

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Cameron James Ferry
Date of birth:	10 July 1986
Date of death:	26 July 2020
Cause of death:	1(a) Chest injuries sustained when crushed by tip truck
Place of death:	15 Allenby Road, Lilydale, Victoria, 3140

INTRODUCTION

1. On 26 July 2020, Cameron James Ferry was 34 years old when he died from injuries sustained in a workplace accident. At the time of his death, Mr Ferry lived in Lilydale with his wife, Anastazya Ferry.

2. Mr Ferry is survived by his wife, his brother Joshua, and his parents, Raymond and Karen.

BACKGROUND

3. In December 2008, Mr Ferry successfully completed a Bachelor of Design (Industrial Design) at Swinburne University of Technology. Throughout 2019, he also completed several accredited units relating to occupational health and safety, high risk work, local risk control, support plant operations and working in accordance with an issued permit. At the time of his death, Mr Ferry held a valid Victorian heavy vehicle driver licence.[1]

4. From 2012, Mr Ferry owned and operated an earthmoving and excavation company with his wife by the name of Camana Pty Ltd (**Camana**),[2] trading as SISU Earth and Civil. The business was operated from Mr and Mrs Ferry's rental property in Lilydale, with Mr Ferry as the sole working director. Mrs Ferry was engaged in full time employment elsewhere and was not actively involved in the day-to-day running of the business. The business had two employees, John Baimbridge and Patrick Westneat.[3]

5. In late April to early May 2020, Mr Ferry purchased a second-hand tip truck from Stephen O'Connor. In his statement to police, Mr O'Connor recalled when they first met on a job site two years prior to Mr Ferry's death, he commented that if Mr O'Connor were to ever sell his tip truck, he would like to buy it. According to Mr O'Connor, Mr Ferry was especially fond of the ease with which the truck could be loaded due to its "*slightly lower*" height and that "*his machines fit in the back of it*". Mr Ferry entered into a payment contract with Mr O'Connor and by the time of his death, had paid $7500 in three $2500 instalments out of the total agreed purchase price of $35,000.[4]

---

1 Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
2 WorkSafe brief, Exhibit 11, ASIC Current & Historical Extract – Camana Proprietary Limited CAN: 159 269 815.
3 Statement of Anastazya Ferry dated 30 July 2020; Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
4 Statement of Stephen O'Connor dated 3 August 2020.

6. The truck purchased by Mr Ferry was a 1994 Western Star 4964FX tipper. The body of the truck was 5 metres in length, longer than the standard tipper body of approximately 4.3 metres. Mr O'Connor advised police that he had purchased the truck 19 months earlier and had it regularly serviced to "*keep it up to scratch and reliable*" and had not encountered any "*issues*" during this period. Although Mr O'Connor did not supply a roadworthy certificate to Mr Ferry at the time he purchased the truck, he was "*confident it wouldn't have needed much to get one*".[5]

7. In her statement to police, Mrs Ferry advised that she expressed concern to her husband about purchasing the truck second-hand, but he and his father reassured her that they "*had both inspected the truck and it was in really good condition*".[6]

8. Shortly after its purchase, Joshua used the truck to move soil on a worksite in Cranbourne.[7] In his statement to police, Joshua recalled that the dirt contained "*really sticky clay*" which clung to the top of the tipper body as it was raised. The weight of the material caused the truck to become unbalanced,[8] which in turn caused the bolts attaching the tipper body to the hinges to be "*ripped out of the frame*" and the tipper body detached from the truck.[9]

9. In his statement to police, Mr Baimbridge recalled that Mr Ferry returned the tipper body to the truck and secured it for transport back to their yard.[10] According to Joshua, after inspecting the damage with his employees and their father, Mr Ferry advised he had identified someone to repair the tip truck by reconstructing the subframe.[11] Mrs Ferry recalled that her husband initially obtained a quote for repairs, estimated to cost between $7000 to $10,000, but he subsequently resolved to complete the repairs himself, given his spare time and "*great mechanical knowledge and ability*".[12]

10. Mr Ferry later engaged James Bottomley, whom Mr Baimbridge described as an "*expert truck body builder*", to inspect the truck and advise them how it could be properly repaired. According to Mr Baimbridge, Mr Bottomley advised that the rear pin and "*some other areas*" needed upgrading, which was later completed. Mr Baimbridge recalled that they also sought

---

5 Statement of Stephen O'Connor dated 3 August 2020.
6 Statement of Anastazya Ferry dated 30 July 2020.
7 Statement of John Baimbridge dated 29 July 2020; Statement of Patrick Westneat dated 26 August 2020.
8 Notwithstanding Mr Westneat recalled the truck became unbalanced after Joshua reversed over a "*bump*", his recollection of the outcome was consistent with Joshua's observations, that the hoist connecting the tub to the truck chassis "*all snapped off*".
9 Statement of Joshua Ferry dated 30 July 2020.
10 Statement of John Baimbridge dated 29 July 2020.
11 Statement of Joshua Ferry dated 30 July 2020.
12 Statement of Anastazya Ferry dated 30 July 2020.

advice from "*experts in the field*" regarding the "*slightly twisted*" chassis and they "*pulled it back into line*".[13]

11. In his statement to police, Mr Baimbridge recalled that he assisted Mr Ferry by drilling a few holes but Mr Ferry largely conducted the remaining repairs himself. He described Mr Ferry as "*very capable with the practical stuff around mechanical and engineering repairs*", given his degree in design engineering.[14]

12. Mr O'Connor was later advised by a mutual friend of the damage to the truck and he contacted Mr Ferry to offer his assistance, however Mr Ferry declined and reportedly indicated he was "*fine*". A short time later, Mr O'Connor visited Mr Ferry with his friend Monty Brill, who had experience in building truck bodies, and they observed the truck parked beside the tipper body, which was placed upon drums. According to Mr O'Connor, they spoke to Mr Ferry about the truck but he "*seemed to have it all under control*".[15]

13. On or around 21 July 2020, Mr Westneat attended the Lilydale residence and observed the tip truck near a shed approximately 30 metres away from the main residence. He recalled that the tipper body was not on the truck and the truck itself was "*under a cover up*".[16]

14. At approximately 4.00pm on 22 July 2020, Mr Ferry telephoned his brother and sought his assistance in realigning the tipper body on the truck. When Joshua arrived at his brother's home, he observed that the tipper body was already in position on the back of the truck. Mr Ferry then used an excavator to align the tipper body with the chassis, while his brother measured and directed him into the correct alignment.[17]

15. According to Joshua, once the tipper body was correctly aligned, his brother "*tack welded the hinges*" that secured the tipper body to the rear of the truck and advised he would "*weld them on properly that night*". Mr Ferry indicated that although he did not need to use the truck that week, he wanted to complete the welding as he was unable to move it until the tipper body was "*permanently welded in place*". Joshua recalled that his brother removed the incorrect "*alignment guides*" that evening, but had not fitted a hydraulic ram to the tipper as this could not be done prior to the completion of the permanent welding that was required.[18]

---

[13] Statement of John Baimbridge dated 29 July 2020.
[14] Statement of John Baimbridge dated 29 July 2020.
[15] Statement of Stephen O'Connor dated 3 August 2020.
[16] Statement of Patrick Westneat dated 26 August 2020.
[17] Statement of Joshua Ferry dated 30 July 2020.
[18] Statement of Joshua Ferry dated 30 July 2020.

16. On 23 July 2020, Joshua telephoned his brother to check on the truck's progress. Mr Ferry reportedly advised that he had "*welded the back hinges on but hadn't welded the front alignment guides on yet*".[19]

17. In his statement to police, Mr Baimbridge recalled that the only remaining repair work was to refit a new hoist, which had already been purchased from Tasmania.[20]

THE CORONIAL INVESTIGATION

18. Mr Ferry's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

19. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

20. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

21. Victoria Police assigned Detective Senior Constable Andrew Austin to be the Coroner's Investigator for the investigation of Mr Ferry's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

22. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths. WorkSafe Victoria (**WorkSafe**) also conducted an investigation and provided a copy of the hand-up brief (**the WorkSafe**

[19] Statement of Joshua Ferry dated 30 July 2020.
[20] Statement of John Baimbridge dated 29 July 2020.

brief) prepared in contemplation of proceedings in the Magistrates' Court of Victoria against Camana. I note that no such proceedings eventuated.

23. This finding draws on the totality of the coronial investigation into Mr Ferry's death including evidence contained in the coronial and WorkSafe briefs. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[21]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

24. Before leaving home at approximately 2.45pm on 26 July 2020, Mrs Ferry spoke with her husband while he was working "on the driver's side of the truck". She recalled that he was using his noise cancelling ear pods to listen to podcasts, as was his usual practice, and believed the tipper body was in the lowered position.[22]

25. At approximately 3.45pm, Mrs Ferry returned home and as she drove up the driveway towards the truck, the observed her husband's legs beside the truck and his upper body leaning into the chassis area between the truck's cabin and tipper body. She spoke to him but he did not respond, and then went inside as she was conscious not to disturb him while he was wearing his ear pods. At approximately 4.20pm, Mrs Ferry went outside to the truck to remind Mr Ferry of their appointment at 4.30pm. She reached out and touched Mr Ferry's shoulder but he did not respond. Mrs Ferry then observed that he was trapped beneath the tipper body and the top chassis section of the truck, with a "*metal wedge through the middle of his back*".[23]

26. Mrs Ferry immediately contacted emergency services and the Metropolitan Fire Brigade, State Emergency Service (**SES**), Ambulance Victoria paramedics and Victoria Police arrived a short time later. Responding paramedics were unable to find signs of life and pronounced Mr Ferry deceased at the scene.

---

[21] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[22] Statement of Anastazya Ferry dated 30 July 2020.

[23] Statement of Anastazya Ferry dated 30 July 2020.

Identity of the deceased

27. On 26 July 2020, John Pascoe visually identified the deceased as Cameron James Ferry, born 10 July 1986.

28. Identity is not in dispute and requires no further investigation.

Medical cause of death

29. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 28 July 2020 and provided a written report of his findings dated 29 July 2020.

30. Dr Lynch reviewed a post-mortem computed tomography (**CT**) scan, which revealed multiple traumatic injuries to chest, namely rib fractures, bilateral pneumothoraces and hemidiaphragm.

31. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

32. Dr Lynch provided an opinion that the medical cause of death was 1(a) Chest injuries sustained when crushed by tip truck.

33. I accept Dr Lynch's opinion.

WORKSAFE INVESTIGATION

34. WorkSafe conducted an investigation into the incident pursuant to the *Occupational Health and Safety Act 2004* (**the OH&S Act**), which involved investigators conducting site visits, taking several photographs of the truck and surrounding area, gathering relevant documents, and obtaining an expert engineering report. The WorkSafe investigation was further informed by the observations of Victoria Police, witness statements and other material obtained during the course of the concurrent police investigation.

35. Police who attended the scene on the night of the incident observed a Volvo brand excavator parked near the truck's rear passenger side wheel. The front arm of the excavator was resting on the ground and its keys were located on the driver's seat. They also observed an open

toolbox near the driver's side door, and a welder and jumper leads towards the back driver's side wheel.[24]

36. At approximately 8.00pm that evening, a heavy haulage recovery team lifted the steel tipper body and SES workers supported the tipper body with adjustable posts to enable an examination by WorkSafe inspectors. Inspectors observed that a hydraulic ram was not fitted between the tipper body and chassis. Laying down between the tipper body and chassis, they located a red square steel bar (**prop or body prop**) approximately 900mm long which appeared to have been used by Mr Ferry *"to prop up the tub as he made repairs to the truck chassis"*. A steel pin was also observed to be protruding horizontally from the side wall of the steel frame of the chassis to which was fitted a square steel pocket (**anchor point**) approximately 90mm in height.[25]

37. They observed metal deformation to the anchor point, and damage to the paintwork on the underside of the tipper body, and to one side of the body prop. WorkSafe inspectors considered that this damage was consistent with Mr Ferry having placed the body prop into the anchor point to support the raised tipper body while he worked between the cabin and tipper body on the passenger side of the truck.[26]

Expert opinion – Management of risk when working with raised tipper bodies

38. WorkSafe engaged engineer John Hambridge of John Hambridge Consulting to provide an expert report with respect to the process and appropriate safety measures for working on, around or underneath a raised tipper body.

39. In preparing his report, Mr Hambridge had regard to photographs of Mr Ferry's truck, the disconnected body prop, and the anchor point underneath the tipper body. He also had regard to the Vehicle Standards Bulletin 6 (**VSB6**) issued by the National Heavy Vehicle Regulator (**NHVR**) and Australian Standard AS1418.8-2008 *Cranes, Hoists & Winches Special Purpose*.

40. Mr Hambridge explained that body props or other like restraint devices are used to position a tipper body in the elevated position and should be engineered and mounted to withstand the unladen load of the body. When placed in the base anchor point, which is designed to

[24] Statement of Leading Senior Constable Elizabeth Davies dated 30 July 2020; Statement of Detective Leading Senior Constable Sharon Dow dated 24 August 2020.
[25] Statement of Jaison McIntyre dated 26 July 2020; Statement of Samuel Roach dated 12 August 2020.
[26] Statement of Jaison McIntyre dated 26 July 2020; Statement of Samuel Roach dated 12 August 2020.

accommodate the diameter of the prop and fit securely around it, the opposite end of the prop should then be mounted to a corresponding receptacle on the underside of the tipper body.[27]

41. Mr Hambridge noted the upper anchor, brace or retainer is generally located on the underside of the tipper body, however this was not visible in photographs provided by WorkSafe. He noted that the prop used by Mr Ferry, shown unsecured in the photographs, appears to have been separate from the assembly and was not fixed at either end. Notably, Mr Hambridge included an extract of section J of VSB6 in relation to body props, which are recommended to be "*permanently connected to the vehicle*".[28]

42. When planning to perform work between the raised tipper body and truck chassis, Mr Hambridge advised that several preparatory tasks should be completed prior to raising the tipper body. These include ensuring the tipper body has been emptied of produce, debris or equipment; ensuring the truck is itself is parked on flat level ground and its tyre pressures are at the recommended setting; and inspecting the rear hinges of the tipper body for excessive wear.[29]

43. The operator must then ensure there are no overhead obstructions that would prevent the tipper body being raised to its full height. They must also ensure that the park brake has been applied and the front and rear tyres are chocked so that the truck remains immobile. Mr Hambridge advised that in the absence of a hoist cylinder, an overhead or mobile crane would be used to raise the tipper body to its full height and a suitably qualified crane operator or dogman should rig the chains or lifting straps.[30]

44. Once elevated, the operator should position the prop at the uppermost position of the tipper body. Mr Hambridge explained that a well-designed prop should allow the operator to reach in and rotate/swing it to the upper anchor position, after which the tipper body is then lowered onto the prop until it is firmly anchored at one end as a minimum requirement. He advised that several different designs of prop exist, including where the uppermost end of the prop is inserted into a receptacle at the underside of the tipper body, or where the top surface is angled to match that of the inclined tipper. Mr Hambridge also indicated that the configuration could

[27] WorkSafe Brief, Expert report of John Hambridge dated 7 September 2020.
[28] National Heavy Vehicle Regulator, Vehicle Standards Bulletin 6 (VSB6): National Code of Practice Heavy Vehicle Modifications, version 3.1, Section J – Body, 'Body props', p8.
[29] WorkSafe Brief, Expert report of John Hambridge dated 7 September 2020.
[30] WorkSafe Brief, Expert report of John Hambridge dated 7 September 2020.

be reversed whereby the prop is suspended from the underside of the tipper body and placed into the corresponding receptable on the chassis.

45. Mr Hambridge cautioned against using a prop when installing or removing a hoist cylinder as this would require the tipper body to be raised and supported at a higher position than the prop would allow. He advised that the nature of this work can cause unpredictable movement of the tipper body or chassis and suggested removal of the tipper body prior to replacing the hoist. Mr Hambridge further cautioned against performing work on, around or underneath a raised tipper body in the absence of props, stands or other suitable lifting gear and safety equipment.

46. Mr Hambridge added that the use of a prop with a raised tipper body was only appropriate when performing "*checks or minor work*". As an alternative, he suggested the use of purpose-built support structures placed between the chassis and tipper body, such as those with angled top pivots which can be angled against the underside of the tipper.

47. Mr Hambridge ultimately recommended the following measures to manage the substantial risks associated with working on, around or underneath a raised tipper body:

    a) A Safe Work Method Statement (**SWMS**);

    a) A risk assessment and the associated to mitigation measures;

    b) Appropriate training and supervision; and

    c) The implementation of suitable props and stands.

Review of records relating to the truck and its use

48. While conducting his examination of the truck, DSC Austin observed compliance placards within the cabin for Western Star Trucks and Transport Certification Services. As a result of further enquiries, DSC Austin identified that the tipper body modification was approved by Transport Certification Services in July 2007.[31]

49. During the course of the investigation, WorkSafe subsequently issued a Notice to Produce to Mrs Ferry on behalf of Camana with respect to records relating to the truck's repair, maintenance and registration history. Mrs Ferry's father, Alex Charaneka, responded on her

[31] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.

behalf and advised that to the best of their knowledge, the truck was roadworthy at the time of the incident. Mr Charaneka also noted that Mr Ferry, as the working director, was the sole decisionmaker with respect to the truck repair and maintenance, including the decision to undertake the repair work himself.[32]

50. Mr Charaneka was unable to produce a copy of policies or procedures relating to the truck's repairs or maintenance, such as site health, safety plans, job safety analyses, hazard identifications, risk assessments or other like documents, nor any records with respect to the management, control or monitoring of such policies or procedures. He advised that as the working director, Mr Ferry was solely responsible for maintaining such documents.[33]

51. With respect to the truck's registration, Mr Charaneka advised that as at the date of the incident, the truck was registered to Camana and was due for renewal on 25 September 2020.[34]

52. Mr Charaneka advised that there was no available documentation recording that the truck required any alterations or modification, and produced a copy of the truck's comprehensive policy with Elders Insurance for which Camana enjoyed a 60% "*No Claim Discount*". Contrary to Mr O'Connor's evidence, the insurance policy described the truck as being "*Fully owned*" by Camana, not subject to finance.[35]

53. Mr Charaneka provided a copy of the SISU Earth and Civil Occupational Health and Safety Policy, which referred to the implementation of the ISO[36] safety management system. The policy outlined several principles by which the company was guided in ensuring compliance with health and safety legislation and industry standards to ensure adequate hazard identification and employee safety.[37]

54. Prior to finalising the investigation, Mrs Ferry, in her capacity as the sole remaining director of Camana, was invited to participate in a voluntary record of interview with WorkSafe with respect to an alleged contravention of the OH&S Act. Mrs Ferry declined to participate in an interview.[38]

[32] Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
[33] Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
[34] Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
[35] Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
[36] International Organization for Standardization.
[37] Response from Alex Charaneka to WorkSafe Notice to produce dated 30 October 2020.
[38] WorkSafe brief, Letter from WorkSafe Victoria to Anastazya Ferry dated 25 November 2020; Statement of Greg Rodgers dated 1 December 2020.

55. WorkSafe subsequently advised the Court on 9 November 2021 that a decision was made not to commence prosecution against Camana in connection with Mr Ferry's death.

FURTHER INQUIRIES BY VICTORIA POLICE

56. DSC Austin, a fully qualified motor mechanic with experience in trucks, agricultural machinery and metal fabrication, attended the property to conduct a further inspection of the truck. He met with Mr Baimbridge and they inspected the fabrication work Mr Ferry performed on the truck, as well as oversized hinges and additional safety chains he had added. DSC Austin considered that Mr Ferry's welding was of a "*professional standard*" and observed that all welds appeared "*symmetrical with good penetration to the metal either side of the weld*".[39]

57. Mr Baimbridge also demonstrated the body prop used by Mr Ferry on the day of the incident, however DSC Austin was unable to view its mounting socket as the tipper was in its lowered position. He noted the damage earlier observed by WorkSafe inspectors and measured the 50mm x 50mm square body prop at 1000mm in length, with a wall thickness of approximately 5mm.[40]

58. DSC Austin subsequently reviewed a video and photographs of the truck obtained by WorkSafe during its investigation. He observed the anchor point or 'socket' mounted on the chassis but noted the absence of a reinforcement or locater on the underside of the tipper body. DSC Austin identified that when lowered onto the prop, the tipper body only made contact with one 50mm edge of the prop. He drew particular attention to the lateral force exerted by the tipper body against the prop when lowered, and indicated that the tipper body itself weighed between 2200kg to 3000kg. Notwithstanding the absence of a secondary contact point, DSC Austin was of the view that the body prop alone should have been sufficient to support the weight of the empty tipper body in its raised position.[41]

59. DSC Austin later examined a truck with a similar, albeit shorter, tipper body that was also manufactured by Northern Engineering. Having inspected its body configuration, including the anchor point location, he similarly observed an absence of a locator or locking mechanism

[39] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.
[40] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.
[41] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.

on the underside of the tipper body that would prevent the body prop from slipping underneath its weight.[42]

60. DSC Austin subsequently obtained a copy of 'General Tipper Body Guidelines' prepared by Jarrod Thompson, Director of Transport Certification Services and a mechanical engineer. Mr Thompson advised that he developed these guidelines as a reference document for the installation of tipper bodies, to be read alongside the relevant manufacturer guidelines and sections of the VSB6 relating to body mounting, chassis frame, tow couplings and brakes by trade.[43] Mr Thompson advised that the need for "*improvement to body prop design and fabrication*" remained a live issue within the industry.[44]

61. DSC Austin also corresponded with Paul Caus, Chief Technical Officer, Heavy Vehicle Industry of Australia, who expressed concerns regarding the lack of body prop design regulations within Australia. According to Mr Caus, any such regulations would be met with difficulties "*due to the engineering complexity surrounding a design that would suit all applications*".[45]

62. In a statement outlining his enquiries, DSC Austin referred to best practice with respect to Elevated Working Platforms and drew a parallel with work conducted by motor mechanics while underneath vehicles, and their use of jack stands as a secondary point of contact in the event of failure of the hydraulic jack. DSC Austin identified several additional safety measures, or mechanical devices alongside a body prop, which could be used to support the weight of a tipper body in the event of prop failure. These measures included the placement of wooden chocks between the tipper body and chassis, props originating from the ground that reached the underside of the tipper body, or supporting the tipper body with a sling suspended from a crane, forklift or excavator.[46]

63. Having later reinspected the truck and obtained several measurements to estimate the elevation angle of the tipper body, DSC Austin formed the opinion that the design of the body prop used by Mr Ferry was incapable of supporting the full weight of the tipper body. He posited that by mounting the body prop at 90 degrees to the tipper body, rather than the truck chassis, the lateral force against the prop would be reduced. DSC Austin also considered that

[42] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.
[43] Transport Certification Services, General Tipper Body Guidelines dated 22 July 2016.
[44] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.
[45] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.
[46] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.

a locating or locking fixture at each end of the body prop would also reduce the risks associated with working on, around or underneath a tipper body.[47]

CONCLUSION

64. As noted above, my role is to establish the facts of Mr Ferry's death, not to cast blame or determine criminal or civil liability. Another important aspect to my role is to help prevent deaths by promoting public health and safety through comments and recommendations if appropriate.

65. While the evidence of Mr Ferry's accreditation and experience in the construction and design industries, together with the accounts of his family and employees, suggests that he was a highly skilled and capable worker, the investigation did not reveal his precise experience in performing maintenance or repair works of the kind observed here. I am therefore unable to draw any conclusions regarding whether or not Mr Ferry was performing work outside of his training and expertise immediately prior to his death.

66. Victoria Police and WorkSafe investigators ultimately concluded that on the day of the incident, Mr Ferry raised the truck's tipper with a small excavator to enable him to prop up the tipper body in a raised position with the steel body prop. He then positioned the body prop in a purpose made recess within the truck chassis before moving the excavator and commencing work underneath the tipper body. While the investigation has not identified the precise circumstances immediately prior to Mr Ferry's death, the evidence suggests that the body prop in question has failed under the weight of the tipper body, causing it to descend upon Mr Ferry.

FINDINGS

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

    a) the identity of the deceased was Cameron James Ferry, born 10 July 1986;

    b) the death occurred on 26 July 2020 at 15 Allenby Road, Lilydale, Victoria, 3140, from chest injuries sustained when crushed by tip truck; and

    c) the death occurred in the circumstances described above.

[47] Statement of Detective Senior Constable Andrew Austin dated 3 September 2020.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

68. Having regard to the available evidence in this matter, it is clear that secondary safety measures, such as those outlined by Mr Hambridge and DSC Austin above, have a role to play in ameliorating the risk of working with elevated tipper bodies.

69. The regulations in force at the time of Mr Ferry's death in relation to body props, namely VSB6 and AS1418.8-2008, outline the function of a body prop or other 'device' in positioning a tipper body in an elevated position, independent of the hoist. With respect to the design of the body prop, VSB6 defers to the Australian Standard which requires the following:

> "*The device shall be provided with the hoist, and shall be accompanied by instructions fitted in a location on the hoist adjacent to the access area. The device shall be designed for easy placement and secured against dislodgement when in use, and shall be stored adjacent to or on the hoist, and suitably identified and labelled.*"[48]

70. I acknowledge the inherent challenges associated with establishing design standards for body props or similar devices when working with raised tipper bodies, noting that there will be variations in tipper body and chassis designs. Notwithstanding, I consider that the intended audience for the VSB6 would be greatly assisted by guidance in relation to safe practices and suggested safety measures for working with body props, such as those devices which provide a secondary contact point in the event of prop failure. I consider that VSB6 does not provide clear guidance in that regard.

71. Having sought his opinion following his initial WorkSafe report, Mr Hambridge indicated to DSC Austin that he shares this view. Moreover, Mr Hambridge described the possibility of an addendum issued by the NHVR in relation to the use of body props as "*both a practical and important amendment to the relevant advice for users of tip trucks and the industry in general*".[49]

[48] Standards Australia, AS1418.8-2008 *Cranes, Hoists & Winches Special Purpose,* 4.4.4(d), p.245.
[49] Statement of John Hambridge dated 23 November 2021.

72. In the time since Mr Ferry's death, the NHVR commenced a review of Section J of VSB6, relating to body mounting for heavy vehicles. During the course of its review, the NHVR drafted a proposed new design code, modification 'J4 – Tipper Bodies', and sought input from organisations within the broader heavy vehicle industry. The initial public consultation process concluded on 19 October 2021 and a second consultation draft was circulated in January 2022.

73. While the proposed content of modification J4 includes a section relating to the use of body props, including a design requirement with respect to strength calculations in supporting the empty tipper body, I am not satisfied that modification J4 in its current proposed form bridges the divide between setting minimum standards of body prop design and communicating their safe and effective use.

RECOMMENDATIONS

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

(i) That the National Heavy Vehicle Regulator consider amending the Vehicle Standards Bulletin (VSB6) or issue a Vehicle Standards Guide to provide clearer guidance on best practice when installing and working with body props on trucks fitted with a tipper body.

I convey my sincere condolences to Mr Ferry's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Anastazya Ferry, Senior Next of Kin

National Heavy Vehicle Regulator

WorkSafe Victoria c/- Phillip Barone, Thomson Geer

Senior Constable Andrew Austin, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 27 July 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.