IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006600

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Kristian David Reinertsen
Date of birth:	22 February 1942
Date of death:	9 December 2021
Cause of death:	1a : Crush injuries sustained in workplace incident
Place of death:	1624 Birregurra-Forrest Road Barwon Downs Victoria 3243
Keywords:	WorkSafe Victoria, workplace death, water tank, oversized goods, manual handing, unloading, crush injuries, preventable death

INTRODUCTION

1. On 9 December 2021, Kristian David Reinertsen was 79 years old when he died due to crush injuries when a water tank fell, striking him. At the time, Kristian lived in Barwon Downs, Victoria. Kristian is survived by his wife, four children and 11 grandchildren, and two great-grandchildren.

2. Kristian was a former Navy serviceman and worked as a Park Ranger in the 1970s. He had a deep love for nature and had an extensive knowledge of native plants and animals. Kristian developed strong connections to the local Aboriginal community and according to his wife, Sue Gregory (**Sue**), *'devoted his life to the land, the community, and learning'*.

3. He is fondly remembered as a generous friend and neighbour. It speaks to his kind and compassionate nature that his final action was to lend a hand.

THE CORONIAL INVESTIGATION

4. Kristian'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Kristian's death. The Coronial 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.

8. This finding draws on the totality of the coronial investigation into the death of Kristian David Reinertsen including evidence contained in the coronial brief. Whilst 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.[1]

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

Circumstances in which the death occurred

9. On 7 December 2021, truck driver, Robert Smith (**Mr Smith**)[2] arrived at work. He had been employed by JBM Logistics (**JBM**)[3] for approximately sixteen months and his role was to deliver water tanks across Victoria and interstate. JBM was contracted by the water tank manufacturer, Polymaster Pty Ltd (**Polymaster**), to complete some of their deliveries.

10. Mr Smith loaded the truck bed and trailer with four water tanks in preparation for departure the following morning. At 6am on 8 December 2021, Mr Smith left the JBM site for Colac. After only 20 minutes of driving the *'engine light'* on the truck came on. Mr Smith turned around, returned to the JBM site where he off-loaded and re-loaded the water tanks onto a new truck.

11. By the time the new truck was loaded, it was 12:30pm and so the scheduled deliveries had to be postponed from 8 to 9 December 2021.

12. Per Thomsen (**Mr Thomsen**) had purchased one of the four water tanks. Initially told that delivery would occur on 8 December 2021, he had *'organised neighbours to be [at his property] to help unload the water tank'*. When he was informed that delivery was delayed by a day, the *'men [he] had organised weren't available'* to help and so enlisted neighbour, Kristian, to help.

13. On his way to Mr Thomsen's property, Mr Smith dropped off two water tanks – of 4,500 and 9,000 litre capacities. He stated that *'these tanks are only small and there was one person there to help [him] unload'* each one. These deliveries occurred without incident.

14. Mr Smith continued to Mr Thomsen's property and arrived at about 9am.

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[1] 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.

[2] A pseudonym.

[3] I note that JBM Logistics (Aust) Pty Ltd ACN 633 477 906 commenced an application for winding up in October 2025.

15. Mr Smith pulled over and spoke with Mr Thomsen and Kristian. The water tank was 31,700 litres in capacity, 4.1 metres in diameter and 3.04 metres tall. It weighed 575 kilograms.

16. Mr Smith reversed the truck and trailer into the Thomsen property. In his statement, he recalled that the planned location of the water tank (where the ground had been levelled and the circumference of the water tank was mapped) was *'awkward'* and he could not position the truck and trailer *'where he wanted to'*.

17. Mr Thomsen reported the planned location of the water tank was approximately '*30 metres from the truck and down a little slope'*.

18. Mr Thomsen's water tank was on the trailer and the three men set about unloading it. Mr Smith stated, *'the best way I could see to get the tank off the trailer was to spin the tank on the trailer then roll it off'*.

19. Mr Thomsen recalled that he and Mr Smith released the straps holding the water tank to the trailer and that Mr Smith suggested *'that [they] turn the tank and roll it off the side of the truck'*. At this time, the water tank was positioned so its flat bottom was parallel to the side of the trailer.

20. Mr Smith stood at the end of the trailer, *'rocking the tank back and forth'* and Kristian stood at the front of the trailer, *'trying to push [the water tank] around'* while Mr Thomsen stood at the other corner of the trailer, also *'trying to push'* the water tank.

21. When the water tank was about half-way turned around, it tipped over, fell off the trailer and landed on Kristian.

22. Mr Smith and Mr Thomsen rushed to the water tank and attempted to lift it, but it was too heavy. Using wood, a steel bar and other items, they were able to prop the water tank up and drag Kristian out from underneath. Mr Thomsen noticed he was unresponsive and did not have a pulse.

23. They alerted Sue, who contacted emergency services and retrieved a defibrillator from the local Country Fire Authority station. The defibrillator showed there was no shockable rhythm. The group performed cardiopulmonary resuscitation (**CPR**) until Ambulance Victoria arrived.

24. Ambulance Victoria paramedics arrived and continued resuscitation efforts. Unfortunately, Kristian could not be revived, and he was declared deceased at 10:12am.

Identity of the deceased

25. On 9 December 2021, Kristian David Reinertsen, born 22 February 1942, was visually identified by his wife, Sue Gregory.

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

Medical cause of death

27. Forensic Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 14 December 2021 and provided a written report of his findings dated 14 December 2021.

28. The post-mortem computed tomography (**CT**) scan demonstrated extensive crush injuries capable of causing death.

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

30. Dr Burke provided an opinion that the medical cause of death was 1(a) *Crush injuries sustained in workplace incident*.

31. I accept Dr Burke's opinion.

POLYMASTER PTY LTD

32. Polymaster is a manufacturer and supplier of liquid storage solutions such as domestic and industrial water tanks, agricultural products, septic tanks, diesel tanks and animal care products. Polymaster water tanks range from 200 to 50,000 litres.

33. The delivery of Polymaster water tanks can occur in a range of ways. Customers can collect water tanks from Polymaster sites, a general courier can be used, or the company can also facilitate delivery. Polymaster has a fleet of trucks and trailers, and salaried employees to complete deliveries. It also contracts JBM to complete deliveries using JBM's own vehicles and staff, as occurred on this occasion.

34. By the time of Kristian's death, JBM had been contracted by Polymaster for *'a couple of years'*.

35. According to the Polymaster General Manager, any contractor – such as JBM – which works for Polymaster is *'subject to [Polymaster] training'*. Training is conducted by Polymaster staff in the operations and logistics business unit, headed by then-Operations Manager, Mark Watson (**Mr Watson**).

WORKSAFE VICTORIA INVESTIGATION

36. WorkSafe Victoria (**WorkSafe**) was notified of Kristian's death and Inspectors attended Mr Thomsen's property on the day of the incident.

37. An Inspector noted that the ground was relatively flat, save for the *'usual bumps and undulations'* of natural ground. The weather was cool; it was overcast and there was *'little to no wind'*. The Inspector formed the view that there were no environmental factors *'that would pose any issue with respect to the unloading of the tank from a vehicle'*.

38. The trailer bed itself was in good condition and was approximately 50 centimetres in height (measured from the ground). A piece of carpet lay across the trailer where the water tank had been, and there was a welded steel chock to hold the water tank in place.

39. Inside the cabin of the truck, Inspectors located a green folder bearing the truck driver's name. Inside, it contained:

    a) A document titled *'Effective Controls/Unloading of Tanks'* bearing the Polymaster logo,

    b) A loading diagram with tank details and delivery information,

    c) The OHS Management System for a delivery to Birregurra-Forrest Rd bearing the Polymaster logo, with three pages of WhereIS maps for Mr Thomsen's address and a Google Maps map of the area,

    d) A Google Maps route from Sebastopol to Barwon Downs and Pennyroyal,

    e) The OHS Management System for a delivery to Pennyroyal-Wymboolie Road bearing the Polymaster logo, with three pages of WherelS maps for a Pennyroyal address and a Google Maps map of the area,

    f) Ten delivery notes bearing the Polymaster logo; and,

    g) A delivery document.

40. Mr Smith confirmed the green folder was his. The contents of the green folder are discussed further below.

Improvement Notice issued by WorkSafe

41. 12 days after Kristian's death, on 21 December 2021, WorkSafe issued an Improvement Notice to Polymaster alleging the company was in contravention of section 23 of the *Occupational Health and Safety Act 2004* (Vic) (**OHS Act**).

42. Section 23 of the OHS Act requires an employer ensure, so far as is reasonably practicable, that persons other than its employees are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer.

43. The Improvement Notice cited information gathered by an Inspector including:

    a) A risk assessment of the unloading of water tanks at customer sites has not been completed to identify possible hazards and risk associated with the task of unloading the water tanks,

    b) It was unclear who determined the number of people required to assist in the unloading of water tanks at the custom site; and,

    c) There was insufficient guidance about the physical requirements or limitations required to be provided by the customer to assist in the unloading of the tanks.

44. The Inspector concluded:

    'I reasonably believe that there is a risk to the health and safety of people other than employees from crush injuries as a result in assisting with the unloading of poly water tanks using manual handling techniques'.

45. The Improvement Notice directed that Polymaster had to provide a safe system of work associated with the unloading of water tanks.

Visit to Polymaster in April 2022

46. On 25 April 2022, an Inspector attended the Polymaster site to check on its progress and compliance with the Improvement Notice. The Inspector was told by Mr Watson and by the Health Safety and Environment Officer:

a) A system of work to unload water tanks by mechanical means had been developed and implemented,

b) The process can be undertaken by a solitary employee who is also able to operate as *'spotter'* during the unloading process to ensure that no person is near the *'fall zone'* (also referred to as a *'drop zone'*) of the tank being unloaded,

c) The employee stands on the same side of the truck that the tank is unloaded to, standing at least 4 metres from the fall zone and having line of sight to the drop zone,

d) The drop zone is 8 x 8 metres and has bollards and chain/bunting in place to indicate the exclusion zone,

e) The employee is able to unload the tank remotely from a distance using a winch system to pull the tank off the side of the truck/trailer,

f) It is '*preferred'* that no other person is onsite during the unloading process, however if there are other persons onsite, they are required to remain in a safe zone at least 15 metres from the fall zone (in line of sight of the truck driver); and,

g) Employees are randomly selected to take a photograph during the unloading process as evidence that the system of work is being undertaken as they have been trained to do.

47. The Inspector was also provided with documents developed since Kristian's death. These will be discussed further below.

48. During the visit, the Inspector was unable to observe a demonstration of the unloading process by mechanical means however was provided a verbal undertaking by Mr Watson that they would receive a video recording of the unloading process for water tanks using Polymaster's updated mechanical method.

49. The Inspector formed the view that the Improvement Notice had been complied with. An additional inspection was conducted on 6 October 2022, and Polymaster provided the WorkSafe inspector with documents relating to and a video of water tanks being unloaded by mechanical means.

Charges against Polymaster

50. In late-2023, WorkSafe filed charges against Polymaster under the OHS Act. On 14 February 2025, the charges were dismissed in the Magistrates' Court due to insufficient evidence to support a conviction.

WATER TANK UNLOADING PROCEDURES ADOPTED BY POLYMASTER AT THE TIME OF KRISTIAN'S DEATH

51. At the conclusion of WorkSafe's involvement, the coronial investigation resumed, having been held in abeyance while the criminal proceedings continued. Throughout the coronial investigation, I have been mindful of section 7 of the Act which requires that the Court avoid the unnecessary duplication of investigation(s) undertaken by other organisations/agencies, such as WorkSafe.

52. Three months before Kristian's death, on 14 September 2021, a Polymaster customer sustained non-fatal crush injuries during the unloading of a water tank.[4]

53. Until this incident, Polymaster adopted a Safe Work Instructions (**SWI**) document to guide the unloading of water tanks by truck drivers. In response to the September 2021 incident, Polymaster was issued an Improvement Notice which outlined measures to be implemented including but not limited to, using vehicles with self-loading cranes, lifting equipment, training for customers to assist with the unloading, unloading exclusion zones and two person deliveries for larger tank types. Polymaster introduced a new system which introduced the exclusion zone for customers, but it did not use any mechanical lifting devices. WorkSafe determined that the Improvement Notice was complied with.

54. One document developed in the compliance process was the *'Effective Controls/Unloading of Tanks'*. This was one of the documents located in the green folder inside the cabin of Mr Smith's truck on 9 December 2021.

[4] This was known to WorkSafe at the time of their investigation.

The Effective Controls/Unloading of Tanks Document

55. The *'Effective Controls/Unloading of Tanks'* document (**Controls and Unloading Document**) was dated 17 September 2021 and provided diagrams and instructions depending on the positioning of the water tank on the truck or trailer – i.e. whether it was placed longways or sideways.

56. Mr Watson described that the document included *'instructions for setting up a drop zone using safety triangles to exclude people from the area where the tank was to be placed and adding competency based training which included each driver unloading a tank in two ways, one in which the tank is rolled on its side of the edge and one where it is dropped on its base'*.

57. Mr Thomsen's water tank was placed *'longways'* so that its bottom ran along the length of the trailer. In this situation, the Controls and Unloading Document sets out the following instructions for unloading the water tank:

    a) Using four orange breakdown triangles, a drop zone of 6 x 6 metres is to be established adjacent to the truck or trailer bed. This area marks the *'intended drop zone of the tank'*; and,

    b) Using an orange breakdown triangle, a designated safety zone is to be established and *'all other people present at the time of delivery are to remain in visual site away from the unloading area'*.

58. When offloading the water tank itself, the instructions were to:

    a) Swivel the tank 90° from its transportation position so that the corrugated sides are facing the side of the truck or trailer. Use chocks or tyres to prevent tank rolling off truck,

    b) Where necessary, place tyres on the ground where the tank will land to cushion the impact. Position tyres correctly to prevent over rolling of the tank,

    c) Position a person/people outside the drop zone at one or each of the drop zone corners furthest from the truck or trailer,

    d) The person/people pushing the tank should watch until the person/people are in position outside of, and at the far end of the drop zone,

e) When all are in position the person/people pushing the tank off the truck/trailer must check verbally that all are in position and ready when this is confirmed they must push the tank of the truck/trailer to land in the drop zone,

f) Once the tank lands, the person/people at the far end of the drop zone shall move along side of the tank at the bottom of the tank or bottom and top if two people and secure the tank in place; and,

g) If at any time you feel the unloading process is dangerous or unsafe, *'DO NOT proceed*' (emphasis original) and contact Management for further directions.

59. The document does not require that the *'person/people'* assisting must have been trained in manually handling the water tanks, or that they be employed or contracted by Polymaster.

60. It was intended that the Controls and Unloading Document be presented to anyone assisting the truck driver to offload the water tanks. A table for signatures at the foot of the page lists the driver and up to three *'Assistants'* who acknowledge *'the process of unloading tanks has been explained and agree to follow any directions given by the delivery driver'*.

61. Mr Watson explained that *'when the customer has read it and asked the driver any questions the customer and anyone who is actively assisting is asked to sign a copy of the document'*.

Training provided to truck drivers on the September 2021 procedure

62. During the visit of 21 December 2021, a Polymaster representative told the WorkSafe Inspector that truck drivers (both employees and contractors) were trained on the contents of the new procedure and had been assessed as competent prior to undertaking unloading jobs.

63. Mr Watson described the training was carried out as follows:

> *'The drivers were initially informed there were new procedures via text message and they were then each organised to come in for the face to face training. The drivers were consulted and in some cases involved in us creating the new procedures.'*

64. However, a WorkSafe Inspector who attended the site on the day of Kristian's death provided the following recollection:

'[Mr Smith] volunteered he had not seen the unloading procedure documents before. He advised the package of documents had been put together by a member of the administration staff and handed to him. He stated there had been a new unloading procedure implemented and he had been given a half-hour course, but he was not aware of the procedure in its written format.'

65. Documentation showed that Mr Smith received training on the Safe Work Method on 9 November 2021, approximately one month prior to Kristian's death. However, when Mr Smith gave oral evidence to the Magistrates' Court of Victoria on 15 August 2024 (prior to the charges being dismissed) he spoke of the poor quality of Polymaster's *'training'*.

66. When asked about the training Polymaster provided on establishing a drop zone, Mr Smith told the Magistrate: *'[. . .] probably at the time, um, I may sort of thought – sort of counted it as training but since leaving, um, Polymaster I've actually done a lot more training, um, and, um, um, now sort of understand what is proper training and, um, um, can definitely confirm that that was not training, um, um. No certificates were given out, no, ah, specific instructions, um, you know that you had to follow, um'*.

67. Mr Smith reiterated to the Magistrate that he believed that the training he received at Polymaster was not *'acceptable training'* and he did not believe it could be called *'training'* at all. He responded to counsel for Polymaster that: *'you keep trying to say it's training but I don't – like, I'm not denying that it didn't happen, um, ah, all I'm saying is I don't believe it was sufficient training so I don't classify it as training'*.

CHANGES TO WATER TANK UNLOADING PROCEDURES IMPLEMENTED BY POLYMASTER IN RESPONSE TO KRISTIAN'S DEATH

68. Following Kristian's death and its involvement with WorkSafe, Polymaster implemented changes to its training and its procedures applying to unloading water tanks from trucks or trailers.

69. The updated procedure, titled *'Safe Work Method – Transportation and Handling of Tanks'* (**the SWM**) dated April 2022, provides comprehensive information on the loading, transportation, site access, drop zones and unloading of water tanks.

70. The cover page states: '*This is a new process in April 2022. All drivers and users must be assessed for competence before undertaking this task themselves'*.

Conduct an on-site risk assessment

71. The SWM establishes that when truck drivers arrive at the delivery location, they are to conduct an *'on site risk assessment'* with the customer to *'ensure risks are identified and controlled'*.

72. A Risk Assessment rubric titled *'Round tanks greater than 9000 litre unloading'* was also developed in April 2022 to facilitate the risk assessments required by the Controls and Unloading Document. Drivers are meant to complete the risk assessment at the delivery site and identify risks associated with activities or tasks.

73. By way of example, identified risks for the task of unloading water tanks include slips, trips or falls, crush of pedestrians, manual handling of the tanks and entanglement of the winch system. Each risk is given a consequence and likelihood score between 1 and 5, which when plotted on a risk matrix, result in a final Risk Rating of Low, Medium, High or Very High.

74. Truck drivers then implement risk control measures, such as setting up the drop zone and calculate the Residual Risk Rating.

Safety Zones

75. With respect to setting up *'Tank Drop Safety Zones',* the SWM states that breakdown triangles are required. A Drop Zone of 8 x 8 metres, adjacent to the truck or trailer bed is to be marked using bollards and a chain barrier. A Spotter Zone is to be established at least 4 metres from the edge of the drop zone with *'clear visibility'* of the entire area.

76. The Observer Safety Zone must also be established, at least 15 metres from the Drop Zone and in the line of sight of the driver. Otherwise, the Observer Safety Zone can be established inside a nearby building or behind a study fence or similar structure.

Winch-assisted water tank unloading

77. Under the heading, *'Unloading onto the Base of Tank'*, the SWM is divided into instructions for *'preparations'* and *'unloading'*.

78. Trucks drivers, when preparing for unloading, are directed to establish the Drop Zone, Spotter Zone and Observer Safety Zone. Directions are provided for loosening the winch cable, and to confirm that observers remain in their designated zone(s) and that the drop zone is clear with no new hazards.

79. The steps for unloading are as follows:

a) Remove water tank tie down ratchet straps, securing pins and any other securing straps,

b) Use a ratchet strap to pinch the two water tank supports closer together to raise the water tank about 3cm off the truck/trailer bed to enable the water tank to be pulled off the truck,

c) Stand at the designated spotters' location and visually inspect area before activating winch,

d) Use the winch control to take up any slack in the winch cable,

e) Use the winch control to unload the water tank while observing the drop zone; and,

f) Disconnect the winch electrics.

80. The SWM also features a *'Theory Competency Test'* comprising four True/False questions and a *'Practical Competency Assessment'* comprising five questions with a Competent/NY [not yet competent] response.

DISCUSSION

81. It is apparent that there were several unmitigated risks that affected Polymaster's practice of unloading water tanks at the time of Kristian's death and that unfortunately, these risks materialised with tragic consequence.

82. Polymaster had knowledge that unloading water tanks carried the risk of harm including to lay people - this had occurred only three months earlier in September 2021.

83. While the company did implement changes in response to the September 2021 incident, these were in my view, not sufficient to adequately mitigate the risk. I acknowledge that WorkSafe concluded that Polymaster had complied with the relevant Improvement Notice.

84. Two key areas of Polymaster's practices that remained suboptimal and which persisted up to December 2021 included:

a) The use of untrained customers and/or lay people to assist employees or contractors to unload water tanks placed them at an appreciable risk of serious injury or death; and,

b) There was poor compliance with the updated procedures given that there is no evidence it was followed on 9 December 2021.

The use of non-trained individuals for manual handling

85. It was Polymaster's practice that customers (and other lay people such as Kristian) would assist its employees or contractors to unload water tanks. The fact this was common practice is evidenced by the need for lay people to sign the Controls and Unloading Document.

86. In my view, a lay person being presented with, and signing, the Controls and Unloading Document was not an adequate substitute for training on unloading the water tanks and was not sufficient to minimise the risk of crush injuries. Nowhere on the document was the risk of serious injury mentioned, despite the document having been created because that risk materialised three months earlier, and caused non-fatal injuries. Based on that document alone, individuals assisting with unloading would have been ill-informed of the risks inherent to manually handling oversized items.

87. Customers were entitled to purchase goods and services from Polymaster and were entitled to believe that they would not be placed at risk of serious injury or death in the delivery of those goods or services. However, the consequence of involving customers and other persons in the unloading process was that untrained individuals were placed in harm's way.

88. In this circumstance, Mr Thomsen and Kristian had not received any training from Polymaster but nonetheless found themselves in a situation manually handling a large water tank, it is unclear whether Kristian appreciated the danger associated with this task, but it appears that he did not. He was a kind man, helping a friend.

89. The fact that Kristian was not the customer and had volunteered to help does not displace Polymaster's responsibility to avoid exposing him to a risk of serious injury or death.

Adherence to the Controls and Unloading Document

90. On the day of Kristian's death, WorkSafe Inspectors asked Mr Smith if the green folder and the documents inside (including the Controls and Unloading Document) were his. He confirmed that they were. Mr Smith stated, however, that he did not have the breakdown triangles referred to in the Control and Unloading Document since his original truck broke down and there were not any stored in the replacement truck. I consider this is a feature of poor resourcing of the JBM truck fleet.

91. As noted, Mr Smith told WorkSafe inspectors that he had not previously seen the Control and Unloading Document before, and that the green folder had been handed to him by an administrative staff member. He was not aware of the document's written form despite having received a 30 minute *'course'* on it. The quality of any training which Polymaster provided to its staff and contractors is questionable, highlighted by Mr Smith's testimony to the Magistrates' Court of Victoria discussed above.

92. In any case, it is clear that Polymaster's procedure was not followed when the water tank was delivered to Mr Thomsen's property, and this resulted in the following omissions:

    a) There is no evidence Mr Thomsen and Kristian were shown the Controls and Unloading Document despite being recruited to assist in unloading the water tank,

    b) Mr Thomsen and Kristian had not signed the Controls and Unloading Document as required,

    c) Mr Smith did not consult the Controls and Unloading Document prior to commencing to unload the water tank,

    d) The equipment, namely the breakdown triangles, required to fulfil the Controls and Unloading Document was not present during the delivery,

    e) There was no Drop Zone of 6 x 6 metres established as required,

    f) Mr Smith did not watch until Kristian was outside of and at the far end of the Drop Zone before pushing the water tank off the trailer; and,

    g) There was no verbal check done to ensure that all persons were ready for the water tank to be rolled off the trailer.

93. Mr Smith was ill-prepared to unload the water tanks on 9 December 2021. There appeared to be an attitude that he could improvise unloading the water tank even though the tank weighed 575 kilograms. Tragically, it was Mr Smith's plan that he could *'take the weight and slowly lower the tank to the ground'* by hand.

94. With regard to *'Loading Tanks for Transport'*, the SWM advises: ***'DO NOT perform this task unless you have been trained and assessed as competent and have been given permission to perform the task by your line manager or contract manager'*** (emphasis original). There is no similar direction for unloading water tanks. While Polymaster has stated that the new system *'does not require the assistance of customer'*, I am concerned that using customers for assistance is not specifically disallowed under the new Polymaster SWM.

95. I will make an apposite recommendation in this regard.

CURRENT INDUSTRY STANDARDS

96. In its document titled *'A guide to handling large, bulky or awkward items'* (**the Guide**)[5] dated April 2012, WorkSafe reminds employers of their statutory responsibility to identify, assess and reduce (as far as reasonably practicable) risks to their employees.[6] This document was in force at the time of Kristian's death.

97. A key message in the Guide is to *'use mechanical aids'*. It states:

    a) *Eliminate or minimise risk through redesigning or repackaging before you proceed to use mechanical aids to handle large, bulky, awkward items.*

    b) *The first preference is to eliminate the need for manual handling by using powered mechanical aids such as forklifts or powered pallet movers.*

    c) *Where it is not possible to use powered mechanical aids, consider using other mechanical aids such as trolleys or hand pallet jacks to reduce exposure to manual handling risk.*

[5] A 'large, bulky or awkward item' is defined in the Guide as being over 25kg and having one dimension greater than 500mm. WorkSafe states that the principles in the guide can be used if employers think they are helpful, regardless of whether the item meets its definition.

[6] WorkSafe Victoria, *A guide to Handling large, bulky or awkward items,* Version 2 dated April 2012 and accessible at: https://www.worksafe.vic.gov.au/resources/handling-large-bulky-or-awkward-items-guide.

d) *Issues such as package design, weight and size, frequency of handling, ease of access to the item to be moved, obstacles along the path of movement, work at height, storage/picking location, item stability, and the distance the item is to be moved will determine the most appropriate aids*.

e) *The effectiveness of any solution involving mechanical aids depends on selecting the correct equipment for the application, maintaining it in a condition fit for its purpose, and ensuring that workers who will be using the equipment receive the necessary training and supervision.*[7]

98. The document notes that a key principle of handling large, bulky or awkward items is that it *'should be done predominantly by powered mechanical means'*.[8]

ACTIONS TAKEN BY POLYMASTER SINCE KRISTIAN'S DEATH

99. Polymaster's practice is now to adopt mechanical assistance for the unloading of large (over 9,000 litre volume) water tanks. This is consistent with the Guide from WorkSafe and its key principle that handling large, bulky or awkward items is to be done predominantly by mechanical means.

100. Noting, however, that this Guide was introduced in 2012, it is regrettable that both the September 2021 incident and Kristian's death occurred before Polymaster introduced a procedure consistent with WorkSafe's industry guidelines.

101. It is nonetheless a positive step to minimise the risks associated with unloading water tanks.

NATURAL JUSTICE

102. Prior to the finalisation of my investigation into Kristian's death and to handing down this finding, the Court gave notice to Polymaster and JBM Logistics of the conclusions which I intended to make and provided them with the opportunity to make final submissions on the same.

103. The Director of JBM Logistics responded and stated it was *'never involved in such incident. JBM Logistics never was contractor or [sic] Polymaster and never engaged Driver MR [Smith].'*

[7] Ibid p 5.
[8] Above n 7 p 6.

104. Polymaster provided its submissions to the Court dated 11 May 2026. Polymaster emphasised that *'at no stage did WorkSafe advice or instruct Polymaster not to use customers in assisting with unloading of tanks prior to the incident on 9 December 2021 despite knowing that was the pre-existing practice'*.

105. I do not consider that the absence of a comment, advice or instruction can be construed as an endorsement. As identified in this finding, Polymaster had sufficient knowledge at the time of Kristian's death arising from the September 2021 incident that persons assisting in the unloading of water tanks were exposed to a risk of serious injury. It was open to them to cease this practice prior to Kristian's death.

Training provided to Mr Smith

106. Polymaster referred to oral evidence that Mr Smith gave to the Magistrates' Court of Victoria.. It submitted that the totality of Ms Smith's evidence was that he *'had attended the training and signed the relevant records, and that the instructions were clear. He confirmed that the training directed him to set up a drop zone approximately six by six metres for the tank, and to advise any personnel helping with the unloading they are not to enter the drop zone at any time until after the tank lands in the drop zone'*.

107. In support of its position, Polymaster pointed to a phone call it alleges occurred between Mr Smith and then-Operations Manager, Mr Watson. Mr Watson claimed that Mr Smith told him: *'It's all my fault I didn't follow any of the new processes I was rushing and not concentrating'*. In Mr Smith's statement made on the day of Kristian's death, he did not reference making any phone calls other than to Triple Zero. In his evidence to the Magistrates' Court of Victoria, Mr Smith could not recall whether he called Mr Watson nor what they may have discussed. There is no evidence to corroborate Mr Watson's account.

108. Even if these remarks had been made, for reasons which I have set out, I consider that Polymaster's *'new processes'* nonetheless placed customers and lay people at an appreciable, recognised and unacceptable risk of serious injury and/or death.

109. The crux of Polymaster's submissions were that Mr Smith had received adequate training on the processes in force at the time and that he was sufficiently familiar with the protocol including to establish a drop zone.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[9] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

   a) the identity of the deceased was Kristian David Reinertsen, born 22 February 1942;

   b) the death occurred on 9 December 2021 at 1624 Birregurra-Forrest Road Barwon Downs Victoria 3243, from 1(a) *Crush injuries sustained in workplace incident*; and,

   c) the death occurred in the circumstances described above.

3. Polymaster had knowledge of the potentially injurious consequences of unloading water tanks however, it nonetheless permitted customers and other lay persons to manually handle its products.

4. While Polymaster took some steps to address the risk of harm between September and December 2021, the evidence is equivocal whether the new procedure was adequately rolled out such as through comprehensive staff training.

5. Mr Smith was unfamiliar with the unloading procedure and consequently, it was not followed at the time of Kristian's death.

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

6. Kristian's death was the culmination of several factors. Namely, a hurried scheduled due to an unforeseen delay, a lack of familiarity with current procedures, and Polymaster's practice that lay people were permitted to participate in the manual handing of oversized goods. These factors carried with them a significant, recognised and on this occasion, largely unmitigated risk of serious injury or death. Unfortunately, this risk materialised on 9 December 2021 with catastrophic consequences.

7. I find that Kristian's death could have been prevented.

8. I acknowledge that Polymaster has taken steps to amend its procedure relating to water tank handling, at all stages of the delivery process, and consider this is a positive step to ensuring the health and safety of employees and non- employees.

COMMENTS

9. It is imperative that water tank manufacturers and suppliers update their processes to use predominantly mechanical means where reasonably practicable when delivering water tanks.

RECOMMENDATIONS

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

10. I recommend that **Polymaster Pty Ltd** update its *'Safe Work Method – Transportation and Handling of Tanks*', to specify that customers and other non-trained personnel should not be involved in the manual handling or offloading of water tanks due to the foreseeable risk of serious injury or death.

ORDERS AND DIRECTIONS

I extend my sincere condolences to Kristian's family and friends, for their loss and acknowledge the tragic nature of his passing. I acknowledge the work that Sue Gregory has done to advocate for safer practices in the industry. I also convey my sincere condolences to Mr Per Thomsen and acknowledge the trauma he has sustained from Kristian's death.

Pursuant to section 73(1A) 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:

Ms Sue Gregory, Senior Next of Kin, C/- Shine Lawyers

Ms Zoe Thomsen, C/- Maurice Blackburn

Polymaster Pty Ltd, C/- Hilliard & Berry Solicitors

JBM Logistics

WorkSafe Victoria

Leading Senior Constable Michael Palmer, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 21 August 2026

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.