LOCAL COURT of NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of David Andrew PULVER**
Date of birth:	24 July 1970
File number:	2010 / 433323
Hearing date:	31 May 2012
Date of findings:	31 May 2012
Place of findings:	Coroner's Court, Wagga Wagga
Representation:	• Sergeant Pike, Police Advocate Assisting • Ms Carroll, representing Sara Powell, Lewis and Lily • Mr Hodgkinson SC, representing Leightons and • Mr McGee, representing Workcover.
Decision maker:	Coroner Megan Greenwood
Findings:	I find that David Pulver died on 1 July 2010 from multiple injuries he received when he was crushed between trucks in a work place incident at the Hume Highway construction site at Tarcutta, NSW.
Recommendations:	***To the Director General of Transport for NSW:*** • That consideration be given to legislative change so that a charge of negligent driving occasioning death can be laid concerning events that occured on private property.

REASONS FOR FINDINGS

Background

1. At about 12.40pm on 1 July 2010, David Andrew Pulver, a 39 year old man, was fatally injured when he was crushed between a reversing front-end loader and his refuelling tanker while working on the Hume Highway construction site of the Tarcutta Hume Alliance. Multiple injuries, including severe abdominal injuries and a broken back, caused David's death.

David Pulver

2. Mr Pulver's family has asked that he be called David in these proceedings.
3. David and his wife, Sarah Powell, had two children, Lewis, is now 6 and Lily, is now 4 years old. David's father, Brian Pulver, mother, Deanne Rutter, and sister, Liza also survive him. Ms Powell and David's family told the court about him and what he meant to them.
4. David was born and raised in Wagga Wagga. After school he commenced work in the fuel industry and never left it. David had a strong work ethic and took pride in doing his job in a safe way and to his best ability. During the hearing it was confirmed that David was a highly respected colleague by all who worked with him.
5. David loved a laugh and always had a story to tell. He was also an avid and very competent sportsman as he grew up and he retained that love of sports and the outdoors into his adulthood. He loved playing cricket, football, golf, motor bike riding, fishing and camping. He was able to play any sport he turned his hand to and in his adult life he excelled at motor bike riding and golf. David had a handicap of three and won many awards. He also followed sports, especially his beloved Collingwood football club.
6. David's family tell the court they have been devastated by his death. His death has had a profound impact on David's children who remain fearful of losing other loved ones. It causes great pain to Ms Powell that their memories of their father will fade. His death has, aside from the grief, placed a heavy child-rearing burden on Ms Powell and she acknowledged the comfort and valuable assistance provided by grandparental involvement in her children's lives.
7. For David's parents and sister, this is the second adult son and brother they have lost and they continue to experience an enormous sense of trauma, grief and loss. Birthdays and Christmases are very difficult times for David's family and it causes them great sadness that David's children will grow up without him and he will not be able to help them celebrate their achievements and milestones. David was much loved.
8. Despite their grief and loss, David's family want to ensure no-one else dies in the way David did. I thank Ms Powell and David's family for giving me an understanding of who David was and what he meant to them.

Investigations

9. Police made enquiries in this matter and Mark Barber, a safety inspector with the *Workcover Authority of NSW* (Workcover), prepared a four volume report. Mr Barber has completed a *Diploma of Injury & Illness Prevention & Management.*

He also has 16 years experience as a NSW police officer, reaching the rank of detective senior constable. His report shows that all relevant organisations and people cooperated with his investigation. Mr Barber's report provided the basis for the factual information included in this decision. He gave very helpful evidence in the hearing.

The project

10. At the time of David's death, the Alliance project was constructing 6.5 kilometres of dual carriageway on the Hume Highway to bypass the township of Tarcutta. The Alliance was a partnership of five entities:
    - Roads and Traffic Authority of NSW
    - Maunsell Australia Pty Ltd (now known as AECOMM)
    - SMEC Australia Pty Ltd
    - Coffey Geotechnics Pty Ltd and
    - Leighton Contractors Pty Ltd (Leightons), which was appointed principal contractor by the Alliance Agreement.

The incident causing David's death

11. The incident occurred near a stockpile of soil in an area of the site known as *"Cut no. 2"*. Terry Wickey was driving a front-end loader. At about 12.40pm on 1 July 2010 Mr Wickey saw David's tanker approaching. Mr Wickey reversed the loader, turned the motor off and stood on the nearside rear mudguard. David alighted the tanker and made his way to the rear of the vehicles, which faced away from each other. He was wearing a high visibility vest.
12. David opened the cowling on the motor at the rear of the loader and removed the fuel cap. David then removed the offside refuelling hose from the rear of the tanker and refuelled the loader. After refuelling, David replaced the fuel cap, closed the cowling on the loader and rewound the hose onto the reel at the rear of the tanker.
13. During the whole process Mr Wickey remained standing on the nearside rear guard of the loader. David completed a written record of the refuelling process, including the engine hours displayed on the loader. Mr Wickey supplied these details.
14. Shortly after David refuelled the loader, Mr Wickey recommenced using the loader and loaded soil from the stockpile into the truck. In doing so, Mr Wickey reversed the loader into the rear of the tanker, crushing David between the two vehicles.
15. Paul Williams was nearby, sitting in his cabin waiting for his truck to be loaded with soil. Mr Williams said he saw David coming to refuel the loader. He stopped, waiting for the loader to be refuelled so it could load his truck. He saw David finish refuelling and completing the paperwork.
16. While Mr Williams could not remember his truck being loaded with soil, the tipper body on his truck was found to be about a third full of soil. He said that he heard the loader engine start, but couldn't remember hearing the reverse alarm. Mr Williams recorded information on his paperwork and looked out the window to see David being crushed.

17. Peter Rossie was driving a truck and dog trailer past the tanker, about 20 metres away. He saw David was at the hose. When he looked that way a couple of seconds later he saw David on his back on the ground.
18. In an interview with Workcover Mr Wickey said:

    .....(I) waited for him to put the hose back, and then jumped in my machine and from then I thought he was gone and I went in and picked a load up and I've dumped it in the truck and as I was reversing back down I have hit David and the other truck.

19. Mr Wickey told Mr Barber that he checked his rear vision mirrors before reversing but, because the loader was articulated, his vision was impeded by the angle of the machine. Mr Wickey thought he was travelling at between 2 and 5 kph. After the collision Mr Wickey drove forward, alighted and discovered David lying on the ground.
20. Mr Wickey immediately raised the alarm. Mr Williams commenced CPR and this was continued until ambulance officers arrived 40 minutes later. At no point was David responsive and he was pronounced dead by ambulance officers. Damage to the rears of the tanker and loader corresponded with the injuries suffered by David.
21. Mr Barber found that while there were some discrepancies between the various witness statements as to the location of the loader in the moments preceding the incident, all accounts were consistent insofar as at the time of the incident David was standing at the rear of the tanker in the vicinity of the nearside with his back to the loader.
22. The facts around David's death raised three questions:
    - were appropriate policies and procedures in place in relation to the refuelling of plant equipment
    - was there appropriate training in relation to these policies and procedures and
    - what procedures were in place to ensure that operators were appropriately qualified and experienced to drive plant equipment on the site?

Systems, procedures & training

23. During the Workcover investigation there were conflicting accounts of refuelling procedures. Two truck drivers indicated it was normal practice for the loader to commence operation while David stood at the rear of the tanker completing his paperwork. Another driver indicated that it was normal procedure for David to leave the area prior to the loader commencing to operate. James Fox, who performed refuelling duties in David's absence, indicated that when he last refuelled the loader he gave permission for the operator to move off while he completed the paperwork.
24. Mr Barber concluded that it was evident from his interviews that a number of plant operators, including Mr Wickey, had not received any training or instruction on refuelling procedures. This is despite a work method statement for refuelling plant on site having been developed in consultation with David and other maintenance personnel. The risk of servicemen being hit by machines leaving the area is specifically identified in the statement. While the document states that the statement must be explained and communicated to all staff, Mr Barber says it was clear that the contents of the document were not explained to plant operators such as Mr Wickey.

Plant & equipment

25. Police officer Detective Sergeant Leanne Wiggins was quickly at the scene on the day of the incident. After David's body was removed from the area, she stood at the rear of the fuel truck as the earthworks foreman, Ian Heard, started the front end loader and reversed it towards the fuel truck. Ms Wiggins reported that the reversing alarm was audible. The UHF radios were functioning correctly in both vehicles and both were set to channel 25. Mr Heard thought that the loader was operating correctly, including the brakes and mechanics of the vehicle and the mirrors were not obstructed. He could see the fuel truck in the left hand mirror, but not the right.
26. Records obtained in the investigation showed that the front-end loader was regularly serviced and maintained.

Workcover actions and Leighton's response

27. On 1 July 2010 Workcover issued an improvement notice to Leightons to undertake an investigation and review of the procedures surrounding the task undertaken at the time of the incident.
28. On 12 July 2010 Leightons developed a four tier refuelling strategy for the worksite. On 21 July 2010 a revised work method statement for plant refuelling was released, incorporating the four tier refuelling strategy. This was followed by the release and implementation of a *Red Book, Working around Mobile Plant.* As a result of David's death the RTA issued a safety alert *Moving plant on construction sites.*
29. Ms Powell sought further information about refuelling strategies that were in place, what training was in place to implement them and whether loaders should be equipped with items such as mirrors and reversing cameras. I am satisfied that the Workcover report comprehensively addresses issues surrounding refuelling arrangements.

Qualifications & experience

30. David had performed his refuelling job for more than two years, working previously on a similar project, the Northern Hume Alliance. His role involved driving his tanker around the construction site refuelling various trucks and plant equipment. David was licensed to drive heavy combination vehicles.
31. After working as a labourer, Mr Wickey attended a community development and employment program in 2002 where he obtained a certificate of competency to operate a backhoe front-end loader and forklift truck. Mr Wickey's operated a front-end loader on a river restoration project in 2009 before working on the Tarcutta project.
32. Mr Wickey commenced working on the Tarcutta site in January 2010, protecting Aboriginal heritage sites. After labouring on the Tarcutta project, Mr Wickey was subject to a verification of competency review and David Town, the Project Trainer/ Assessor, mistakenly concluded that Mr Wickey's credentials entitled him to operate a front-end loader.
33. Mr Wickey advised Mr Town of his experience in operating a smaller front-end loader and that he had no experience in the loading of truck and dog trailer combinations. Additional training was proposed and this commenced on 28 May 2010. Leighton employees, Mr Town and Ian Jones, instructed and supervised

Mr Wickey, focusing on bucket control of the loader, loading of truck and dog trailers with material from the stockpile, maintaining a level floor surface and daily machine maintenance. Mr Barber noted that the training did not include loader refuelling tasks or procedures that were conducted on a daily basis.

34. On 1 July 2010 Mr Wickey held:
    - NSW motor vehicle learner's permit
    - Workcover issued certificate of competencies:
        - Queensland certificate card no. 1650133 to operate a backhoe front-end loader
        - Queensland certificate card no. 1650118 to operate a forklift truck
        - NSW certificate card no. 132401 to operate a skid steer loader and
        - General induction construction card no. CG 101756535EQ1.
35. Clause 266 of the NSW *Occupational Health and Safety Regulation 2001* defines the operation of a front-end loader as scheduled work. Persons undertaking scheduled work must hold the relevant certificate of competency for use of, in this instance, a front-end loader or be trained on a log book under the supervision of a competent person. On the day of the incident Mr Wickey met neither of these requirements. Nevertheless, those persons Mr Barber spoke to considered that Mr Wickey operated the loader in a competent manner.
36. There was one prior incident that occurred on 28 June 2010. On that day, while loading a truck, Mr Wickey's loader came into contact with the offside section of the truck's rear trailer. A report was made and it was written up. As a result Mr Wickey underwent remedial training.

Conclusions

37. I considered that one issue should be the subject of evidence in a hearing:
    - whether any road laws should apply to large scale construction sites, for example whether operators of plant equipment should be required to hold a driver's licence.
38. The officer in charge of the Police investigation, Detective Sergeant Leanne Wiggins, was unavailable to give evidence. While not responsible for the conduct of the investigation, the second in charge, Senior Constable Scott Trewhella gave evidence instead.
39. He told the court that two possible criminal charges might have been considered against Mr Wickey. The first, negligent driving occasioning death required that the incident occur on a road or road-related area. Officer Trewhella told the court that he believed the construction site would not be found to be a road or road-related area and therefore the charge could not be laid against Mr Wickey. He formed this view because there were traffic barriers, gates, a site controller preventing access and a stop sign where anyone wishing to enter had to identify themselves.
40. Officer Trewhella said the more serious charge of dangerous driving occasioning death generally relied on the manner of driving, speed and use of alcohol or drugs. While the requirement for a road or road-related area is not necessary for this charge, it was Officer Trewhella's view that there was most likely insufficient evidence to enable the laying of the charge.
41. Officer Trewhella told the court that he was aware of similar matters where negligent driving occasioning death charges might have been laid, but for the incident occurring on private property. He gave an example of a person riding in the back of a utility vehicle on a working farm and then dying after a fall from the

vehicle. Officer Trewhella expressed a private opinion that there was a deficiency in the law and that a charge of negligent driving occasioning death should be able to be laid concerning events that occur on private property.

42. Mr Barber's evidence was also useful. He explained that the occupational health and safety legislation places considerable onus on the controllers of workplaces to ensure the safety of workers and visitors. He also explained the criminal charges that can be laid for breaches of the legislation and that those charges can be laid on all those culpable, from managers through to workers.
43. Mr Barber agreed that he had not recommended charges against Mr Wickey. He said this was because he believed the issue was one of refuelling and he couldn't be satisfied that Mr Wickey had been properly trained or instructed in that task.
44. Mr Barber noted that NSW Police and Workcover have a formal agreement to cooperate and exchange investigative information. They can also refer matters to each other so that separate or parallel investigations can be conducted.
45. He told the court that, in relation to the ute example, Workcover would assess whether the incident was work-related. If it wasn't, Workcover would not investigate.
46. Mr Barber noted that there has been a change to the requirements for those who operate load-shifting machines since he wrote his report. With the introduction of the new *Work Health and Safety Act*, a harmonised national scheme, these operators no longer needed a certificate of competency. What is now required is that a controller of a worksite must ensure that the operator is competent to do the job required, having regard to the particular circumstances of the work site. It was submitted that the new legislation could be regarded to be a strengthened approach to workplace safety.
47. Mr Barber expressed the view that the requirements on large construction sites are very different to those on roads and road-related areas. He said that the legislation and accompanying regulations and other policies and guidelines were designed to ensure that each worksite addressed the specific risk issues appropriate to the site, rather than a one-size fits all solution. In particular, he felt that difficulties might occur if road rules were to apply to these sites as:
    - other systems and procedures are much more important and possibly conflicting with road laws, such as the requirement for site-specific traffic control or vehicle management plans and heavy vehicle work method statements. These applied to the site when David was working on it
    - the shapes, sizes and other difficulties of some sites would make it confusing and dangerous for workers if road rules also applied and
    - some plant equipment would not be registrable.
48. In relation to the issue of driver licensing, I found the evidence about the new *Work Health and Safety Act* persuasive. The continued move to site-specific competency and risk assessment must improve the safety of workplaces. Site-specific traffic management and refuelling plans do seem to be of more importance in ensuring safety than a driver's licence and the skills and training that accompany it. I can also see how the varying nature of construction sites may require the operation of plant in a way that is at odds with road laws and it is important for safety reasons that there be as little confusion as possible.
49. I am satisfied, however, that there is merit in the consideration of enabling a charge of negligent driving occasioning death to be laid concerning events that occurred on private property.
50. A number of recommendations were included in the Workcover report, which reflected an extremely thorough and extensive investigation. I am satisfied the report sufficiently discloses the place, date, manner and cause of David's death.

I adopt the report and its recommendations. I also find there is no evidence that an identifiable person has committed an indictable offence in relation to David's death.

51. I express my condolences to David's children, Ms Powell, his parents, sister and their families.

Findings

52. I find that David Pulver died on 1 July 2010 from multiple injuries he received when he was crushed between trucks in a work place incident at the Hume Highway construction site at Tarcutta, NSW.

Recommendations

53. To the Director General of Transport for NSW:

- That consideration be given to legislative change so that a charge of negligent driving occasioning death can be laid concerning events that occured on private property.

Megan Greenwood
NSW Coroner