Form 37

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference:
Inquest into the Death of Lani Rose TAYLOR
Delivered on: 16 August 2013
Delivered at: Mildura
Hearing dates: 5, 6 and 7 August 2013
Findings of: Richard Wright
Representation:

Place of death: Colignan, Victoria

Assisting the Coroner: Senior Constable Cherree Blair, Victoria Police

In the Coroners Court of Victoria Mildura

The following appearances were recognised, with the Parties represented also listed:

Mr Hugh Middleton	The Family of Lani Taylor
Mr Trevor Wraight	WorkSafe Victoria
Mr Ian Ryan	Mr Gage Maher

I, Richard Wright, Coroner, **having investigated** the death of LANI ROSE TAYLOR with an Inquest held at the Mildura Court House, Mildura on 5, 6 and 7 August 2013.

Find that the identity of the deceased was LANI ROSE TAYLOR and that death occurred on 8 May 2011, between the hours of 1100 and 1230 hours, at Brownport Almonds, 747 Brownport Road, Colignan, from:

1a MECHANICAL ASPHYXIA

In the following circumstances:

Background

Lani Taylor was employed by Brownport Almonds Pty Ltd as general farmhand, with her partner, Gage Maher. The relationship between Lani and Gage had commenced in mid-2010 and they had lived together for approximately 8 to 9 months. They came to the Mildura region in late 2010. Mr Maher had gained employment at Brownport Almonds in February, 2011. Ms Taylor also gained employment with Brownport, commencing work on 8 April 2011. Both were on a trial period with Brownport, but were well regarded as workers. The couple were saving to finance a bond on a rental property and their bank accounts were intertwined. Evidence was given that Ms Taylor's earnings were basically saved and the couple lived off Mr Maher's income.

Circumstances

Mr Maher detailed that he and Ms Taylor were working on together on Sunday, 8 May 2011. They had arranged to work that day with the Farm Manager, Mr William Craik. On their arrival at the property, it was discovered that Mr Craik had overlooked this arrangement, but they were quickly tasked. Initially, Ms Taylor was asked to work straightening dripper lines for the orchard's irrigation system, but she expressed a preference to do "spot" spraying of weeds.

Mr Maher was to drive a four-wheel drive Kawasaki "Mule", towing a retractable boom sprayer. Ms Taylor was driving a smaller, two-wheel drive "Mule 600" fitted with a 200 litre spray tank and spray equipment designed for "spot" spraying. Spot spraying was used to attack weeds that were not accessible to the boom sprayer.

Brownport Almonds in Colignan is a 404 hectare or 1000 acre property, with 137 hectares or 340 acres holding 36,000 mature trees. Ms Taylor and Mr Maher were working in an area of young trees. In terms of the farm's layout, the area was designated as B2, B3 and B4, an area of approximately 70 hectares or 170 acres. The trees were spread across a hillside and in undulating country, preventing vision from one end to the other. As the pair worked, they would see each other from time to time, but were basically independent.

At about 10 am to 10.30 am, Lani Taylor walked over to where Gage Maher was working. Her vehicle had run out of fuel. The pair returned to the machinery shed to have "smoko" and fill a jerry can of fuel for the Mule 600 Lani was driving.

After "smoko", Gage Maher drove Lani back to her vehicle and refuelled it for her. The last he saw of Lani alive was as she was driving her Mule 600 back to the shed to return the jerry can. This was thought to have been around 11 am.

Mr Maher returned again to the shed at 12.30 pm for lunch. He met Mr Craik there. As Lani had not come in, he decided to drive in his own vehicle to pick her up for lunch at the Nangiloc Store. As he travelled down the internal roads on the farm, known as a "headlands", he noticed the Mule 600 stationary and on its side. He found Lani pinned beneath the left hand side of the vehicle. She was deceased.

Mr Maher says he tried to lift the Mule 600 off Lani, but was unable to do it. He rang Mr Craik for assistance and the two of them were able to "right" the Mule 600. On advice from the operator at "000", CPR and "mouth to mouth" resuscitation was commenced. An ambulance and police were dispatched to the scene. WorkSafe attended, as did Detective Senior Constable Lewin, the officer on duty in the Mildura Criminal Investigation Unit.

Mr Lewin concluded from his observations of the accident scene that this was not a criminal matter and the initial investigation was left to WorkSafe. Because of the circumstances of Lani Taylor's death, an autopsy was required and an Inquest ordered.

Investigations

The inquest brief was authored by Detective Senior Constable Brenton Lewin, who was also the Informant in this matter. He was called to give evidence to the Inquest, on his role as the Police investigator into the death. WorkSafe Victoria conducted its own investigation. The WorkSafe investigation report and all the witness statements collected by WorkSafe and Victoria Police formed part of the brief.

At the conclusion of the WorkSafe investigation, no charges were laid for breaches of the Occupational Health and Safety Act 2004. Victoria Police concluded that there were no suspicious circumstances surrounding Lani Taylor's death. The autopsy conducted at the Victorian Institute for Forensic Medicine also concluded that no suspicious circumstances were revealed in the autopsy.

Role of a Coroner

The coroner's function is investigative and inquisitorial rather than adjudicative and adversarial. Coroners are required to investigate matters in their jurisdiction and, in the case of a death, determine the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death.

It is clear that the identity of the deceased and the cause of death, in this case, are known. The primary inquiry for the Coroner relates to the circumstances of the death.

The Inquest

As noted above, an Inquest into the death of Ms Lani Taylor was conducted in Mildura on 5, 6 and 7 August 2013. Senior Constable Cherie Blair assisted the Coroner.

The following witnesses were called to give evidence at the Inquest:

Mr Gage Maher	Mr Maher was Lani Taylor's partner. He was employed by Brownport Almonds and was working with Ms Taylor on the day she died. He found her after the accident.
Mr William Craik	Mr Craik is the farm manager at Brownport Almonds. He employed both Ms Taylor and Mr Maher. He assisted in "righting" the Mule 600 after the accident and commenced CPR.
Mr Trevor Southgate	Mr Southgate is the service manager of GBC Motors Pty Ltd. He was required to check the Mule 600 for driveability, service status, general condition and wear and tear.
Mr Peter Spindlow	Mr Spindlow is National Technical Service Manager for Kawasaki Motors Pty Ltd, the importer of the Mule 600. He

	gave evidence on the technical capabilities and uses of the Mule 600, as well as comparable vehicles in the Kawasaki range.
Ms Susan Johnston	Ms Johnston is a WorkSafe Inspector, tasked to attend the accident and provide an initial report. She also issued Prohibition and Improvement Notices against Brownport Almonds under the Occupational Health and Safety Act 2004.
Detective Senior Constable Brenton Lewin	As noted above, Mr Lewin conducted the initial criminal investigation of the accident scene and was responsible for preparing the Inquest Brief.
Sergeant Kaare Anderson	Sergeant Anderson was the senior uniformed officer attending the accident scene. He spoke to various witnesses and emergency workers in attendance.

The Witnesses

Ms Blair called the witnesses to give evidence. Their respective statements in the Inquest Brief were read into the transcript of proceedings in the Inquest.

Mr Gage Maher

Mr Maher made two sworn statements in relation to the circumstances of Lani's death. The first, dated 22 June 2011, was made to a WorkSafe Inspector. The second, dated 8 October 2012, was made to Victoria Police. He was examined on his sworn statements and general recollection of the events, as well as his relationship with Lani.

It is fair to observe that there were some variances between the statements and evidence, between each other and the evidence of other witnesses. For instance, Mr Maher maintained that he came into possession of Lani's jewellery through Sergeant Anderson. This is denied by the Sergeant. None of these variances and inconsistencies were of significant relevance to the issues before the Inquest. Mr Maher stated that it was he who had instructed Lani in how to drive the Mule 600, although Mr Craik also gave evidence on instructions he had given Lani in relation to driving the vehicle. From Mr Maher's observations, she was a steady driver who did not speed. Statements taken from other farm workers were at variance with Mr Maher's view of the speed of Lani's driving.

Notwithstanding Lani's relative inexperience in driving, Mr Maher was of the view that she had the skills to correct drifts of the vehicle in the light soils of the farm. Mr Maher also gave evidence of a slow air leak in the front left tyre. This statement can be contrasted with the vehicle inspection conducted by Mr Southgate, where he found the tyre pressure in the left front to be 10 psi, but the right hand front tyre was down

to 4 psi. Mr Maher also stated that the front tyre had been filled with some anti-leak compound by Mr Craik. Mr Craik had no recollection of doing this.

Mr William Craik

As noted above, William Craik was the manager of the farm and lived on the property. His evidence was that he had not had a chance to properly induct Lani Taylor into work on the farm, due to the pressure of work when she commenced. He did recall giving some instruction on driving the Mule 600 when he discovered she had commenced driving the vehicle. His evidence was that he told Lani to wear the seatbelt, how to check and fix the battery terminals, and not to speed in the vehicle.

In retrospect, Mr Craik was prepared to admit that Lani Taylor was probably not given enough training.

Brownport Almonds was served with Prohibition and Improvement Notices under the Occupational Health and Safety Act. As a consequence of these notices, a safety audit was conducted and a number of improvements were made to the operation's approach to training and signage. These actions were implemented under Mr Craik's supervision.

Mr Trevor Southgate

After the fatal accident, Mr Southgate was retained by Victoria Police to conduct a thorough review of the Mule 600. The vehicle had been impounded by Victoria Police and was held in Mildura. GBC Motors collected the vehicle on 11 May 2011 and spent the day doing tests. A **Safety Inspection and Report** was prepared for the Police.

In Mr Southgate's view, the Mule 600 was a very stable vehicle. In his statement he recognised the crucial role served by the seat belt in the safety of drivers and passengers in a Mule 600. The vehicle was protected by a sturdy roll cage covering the seating area. In any tipping scenario, it is the seatbelt that holds a person within the cage.

His statement remarks that if the Mule 600 wheels lifted in a manoeuvre, a simple counter-steering would correct the instability. In his evidence, he conceded that a young, inexperienced driver would be unlikely to have the requisite skills or experience to execute such a correction.

Mr Southgate's statement contains the following observation:

> "The spray tank contained just under the 100 litre mark and would not have created undue force to cause the roll over."

Mr Southgate was questioned on this statement during the Inquest. His conclusion was based on his observation during his testing. He acknowledged he did not "push" the vehicle to its extremes of stability and he could conceive of situations in which the behaviour of the fluids in the tank could have been significant. The matter of the

stability implications of the partially filled spray tank was later referred to the Major Collisions Unit.

Mr Peter Spindlow

Mr Spindlow is National Service Manager for Kawasaki Motors Pty Ltd. Kawasaki import the Mule 600 for sale in Australia. He estimate there are approximately 4,000 Mules in various models and setups sold in Australia since the mid-1990s. They have a wide application in a diverse number of industries and services, such as agriculture, military, mining and in the recreational sector.

His evidence was that the Mule 600 was quite stable vehicle, they can be tipped in certain conditions. He recounted and example where one was turned over on a dealer presentation day.

In response to a question from Ms Blair, Mr Spindlow was of the view that a half-filled unbaffled tank of the type Lani Taylor was carrying could be problematic in cornering. Depending on speed, the sudden shift of liquid would increase the height of the load, and exert a destabilising lateral force on the vehicle.

Ms Susan Johnston

Ms Johnston was the WorkSafe Inspector detailed to the accident at Brownport Almonds. She arrived at the accident scene at around 3.15pm on the day of the accident. At the Inquest, Ms Johnston tendered a number of photographs taken at the scene, showing the accident site, the Mule 600, the spray tank and assorted items that had been in the Mule. She also photographed the unused seatbelt and the warning sign urging users to fasten the belt. Using her powers under the Occupational Health and Safety Act, Ms Johnston seized the Mule 600.

In Ms Johnston's view, Brownport Almonds was in contravention of section 21 of the Act. The day after the accident, she served the Notices of Improvement and Prohibition on the Company. She also filed WorkSafe Entry Report on the accident.

In relation to safety at the Brownport Almonds operation , Ms Johnson was of the view that it was more a documentation issue, rather than a systemic failure in the Company's approach to safety. Mr Craik had taken adequate steps to train staff and enforce safety standards.

Detective Senior Constable Brenton Lewin

At the time of the fatality, Mr Lewin was attached to the Mildura Criminal Investigation Unit (CIU). He was the duty detective on the day of the accident and attended the scene. When he arrived at the scene, uniformed officers were already in attendance.

As noted above, on the basis of discussions with Police in attendance and his own inspection of the accident scene, Mr Lewin was satisfied that this was not a crime scene.

Mr Lewin was responsible the preparation of the Coroner's brief in this matter. He collated interviews with a large number of people and liaised with Police who

conducted enquiries into matters that arose subsequent to the accident. In evidence before the Inquest, he did not resile from his original conclusion that there was no criminal aspect associated with Lani Taylor's death.

Sergeant Kaare Anderson
On being advised of the fatality at Brownport Almonds at 1.26pm on 8 May 2011, Sergeant Anderson and Senior Constables Phillips and O'Flaherty left Mildura Police Station to attend the scene. The Police arrived at Nangiloc property at 2.10pm, where they were met by Mr Craik and his son at the front gate. They were led to the scene of the accident. In Mr Anderson's opinion, the scene was relatively "contaminated" by the comings and goings of people at the accident site. Ambulance was already on the scene.

In his statement for the Inquest, Mr Anderson detailed his conversations with the Ambulance Officers and the employees of Brownport Almonds in attendance. He contacted the Major Collision Investigation Group. The Group's policy is not to inspect vehicles involved in workplace fatalities. These incidents are within the scope of WorkSafe and CIU. Major Collisions gave instructions on critical measurements that needed to be taken to estimate the speed of the Mule 600 at the rollover.

Sergeant Anderson also contacted Lani's father, Mr Chris Taylor and conveyed the news of Lani's death. At the Inquest, Mr Anderson observed that this mode of communicating the sad news was not ideal, but he knew the news of the death would soon be "on the News". In his assessment it was appropriate to call Mr Taylor in these circumstances.

To quote from Sergeant Anderson's sworn statement tendered at the Inquest:

> As an overall comment I would say that it appears to me that the accident has occurred as a result of an inexperienced driver who, whilst driving a relatively unfamiliar vehicle, has executed a right hand turn too quickly whilst travelling on an uneven surface. The movement of the liquid, in this case 90 litres, to the left side of the spray tank carried in the rear of the tub of the vehicle, coupled with the vehicle being left hand drive has effectively resulted in all the weight being transferred to the left side. All the weight being on the left side as it turned right has resulted in the vehicle tipping over to the left, throwing the deceased, who at the time was not wearing a seat belt, out of the vehicle which has landed on top of her.

As will be shown below, an expert scientific review of the accident, conducted for the Coroner by the Major Collisions Accident Group, comes to exactly the same conclusion.

Submissions

Mr Middleton made extensive submissions on behalf of Lani Taylor's family. His concerns were principally concerning the amount of training Lani received on farm practices generally and operation of the Mule in particular. He said there was no induction available on her commencement. Lani was allowed to drive without a licence. There was no hazard assessment and recording process in place. He alleged that the farm was lax in relation to safety in relation to use of seatbelts, vehicle

maintenance, including tyre pressures, the condition of the windscreen, the warnings in relation to the hole in the headland near the accident site and the fact that the spray tank was unsecured and unbaffled. He also urged that the Major Collisions Accident Group should be involved in the investigation of farm accidents where a vehicle is involved, or at least allow WorkSafe inspectors access to its expertise. He was also of the view that Lani could have been tasked to drive the larger more stable, four wheel drive Mule.

The fact that the larger Mule was to tow a separate spray unit might well be a reason that it was not entrusted to a less skilled employee, but this was not put to Mr Craik.

Mr Wraight for WorkSafe responded to Mr Middleton's submissions. In relation to training of employees by Brownport Almonds, he noted that the evidence from the Inspectors was not that the training was inadequate, rather it was undocumented. He drew the Inquest's attention to section 20 of the Occupational Health and Safety Act:

> **20 The concept of ensuring health and safety**
> (1) To avoid doubt, a duty imposed on a person by this Part or the regulations to ensure, so far as is reasonably practicable, health and safety requires the person—
> (a) to eliminate risks to health and safety so far as is reasonably practicable; and
> (b) if it is not reasonably practicable to eliminate risks to health and safety, to reduce those risks so far as is reasonably practicable.
> (2) To avoid doubt, for the purposes of this Part and the regulations, regard must be had to the following matters in determining what is (or was at a particular time) reasonably practicable in relation to ensuring health and safety—
> (a) the likelihood of the hazard or risk concerned eventuating;
> (b) the degree of harm that would result if the hazard or risk eventuated;
> (c) what the person concerned knows, or ought reasonably to know, about the hazard or risk and any ways of eliminating or reducing the hazard or risk;
> (d) the availability and suitability of ways to eliminate or reduce the hazard or risk;
> (e) the cost of eliminating or reducing the hazard or risk.

He said that the evidence before the Inquest was that Brownport Almonds had done and was doing all that was reasonably practical, it s "fault", if any, was that the steps were not formalised. They had subsequently brought in professional help to audit its practices and formalising them. The safety expert retained by Brownport Almonds had to develop a safety program in relation to vehicles like the Mule from the "ground up". After extensive research, he could find no suitable program in operation at other places.

Mr Wraight also addressed Mr Middleton's concerns about the windscreen of the Mule 600. Mr Middleton in his submissions had observed that there was dust on the windscreen which would, in full sun on the screen, have prevented a driver from seeing through the screen effectively. This may have contributed to the accident. Mr Wraight observed that at the time of the accident, the sun would have been behind Lani.

Findings

I find that Lani Taylor's death was accidental, caused when the vehicle she was driving rolled on a right hand turn on a farm track. She was not wearing a seat belt at the time and this may have contributed to her death. The vehicle was carrying liquid spray in an unsecured and unbaffled tank in the back. The affect of a sudden right turn at speed on the vehicle's centre of gravity may also have been a contributing factor.

Expert Evidence on Vehicle Speed

At the conclusion of the Inquest, Mr Middleton for the family, asked if the Major Collisions Accident Group could provide an estimate of the speed of the Mule 600 as it approached the right hand bend. An opinion was provided by Detective Senior Constable Hay. On the basis of the measurements of the curvature of the bend in the road and an estimate of the friction factor of the road surface on the farm, Mr Hay estimated the speed of the Mule in the range of 26-29 kph. These speeds can be contrasted with the maximum speed of the vehicle published by Kawasaki at 35 kph.

Mr Hay was also asked for his opinion on the role the unbaffled spray tank could have had on the handling of the Mule 600, as it negotiated the right hand bend at speed. He noted that a 90 litre load in the spray tank can be contrasted with the overall weight of the Mule 600 of approximately 430 kg., 20% of the Mule's mass.

On right cornering sharply, this liquid would move rapidly to the left side of the tank and rush up the left wall. At that time, the centre of gravity of the Mule 600 and its load would rise and move it to the left of the vehicle. The combined affect of this shift of the centre of gravity would make the critical speed for rollover less than if there was no liquid in the tank on the back.

Recommendations

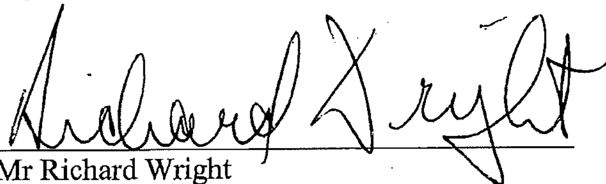
Any death in a farm accident is a tragedy. Where the death is that of a young, vibrant woman, as here with Lani Rose Taylor, it is infinitely sadder. A number of proposals have been put to the Inquest, to militate against the recurrence of similar events. The suggestions have gone to training of employees in safe use of farm vehicles and associated matters. Improvements to vehicle design have also been recommended, addressing stability issues and accident prevention.

A Coroner has an undoubted power to make recommendations to Government and government agencies. In making a recommendation, a Coroner needs to be aware of a number of issues. In relation to farm safety, it is clear that WorkSafe Victoria has an active program in this area. I am confident that there are processes in place within that organisation to take what has been learnt in this fatality and build it into education and enforcement programs of that organisation. As a consequence, I do not feel I should make any separate recommendation in this regard.

As to the question of design improvements for farm vehicles, as suggested by Mr Middleton, I would conclude that the Kawasaki Mule 600 is a relatively safe vehicle, when operated within its design capabililities. Research indicates that this is the only fatality in Australia involving a vehicle of this design type. The Mule 600 in the configuration here is a fairly basic vehicle, designed for a particular type of job. There are more sophisticated configurations of the Mule with a more "sporting" application,

carrying more sophisticated safety options. To mandate design features such as "tip" warning gauges, etc, in the base agricultural-type Mule, although making the vehicles marginally safer, would in my view be unnecessary, given their relative stability and slow top speed.

Signature:



Mr Richard Wright
Date: **16 August 2013**