IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 4461

FINDING INTO DEATH WITHOUT INQUEST

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

I, AUDREY JAMIESON, Coroner having investigated the death of Philip Stanley Dickson

without holding an inquest:
find that the identity of the deceased was Philip Stanley Dickson
born 18 October 1949
and the death occurred on 2 October 2008
at 1630 Little Yarra Road, Powelltown, Victoria, 3797
from:

1 (a) Multiple injuries

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mr Philip Dickson was 58 years of age at the time of his death. He was employed as a forklift operator at the Powellton Sawmill and had worked in the timber industry for most of his life. At the time of his death he resided at Warburton East with his defacto partner of 22 years, Ms Patricia Ingram. He was the father of Mr Mark Dickson.
2. At approximately 2.10pm, Thursday 2 October 2008, Mr Dickson was performing duties in a timber drying shed, when a large stack of timber fell upon his body whilst he was in a kneeling position. A fellow employee discovered the incident and a rescue attempt followed. Ambulance Victoria were called to attend however Mr Dickson was unable to be assisted and died at the scene.

INVESTIGATION

Medical investigations

3. An autopsy was conducted by Dr David Ranson, Deputy Director, Victorian Institute of Forensic Medicine who determined the cause of death as 'Multiple injuries' consistent with a crush type injury.

4. The autopsy revealed evidence of significant natural disease in the form of coronary artery atherosclerosis with areas of up to 80% occlusion of the anterior descending branch of the left coronary artery.
5. No drugs or alcohol were detected in Mr Dickson's system.

Worksafe investigation

6. The death of Mr Dickson occurred in the workplace and as a result, Powelltown Sawmills Pty Ltd (referred to in my finding as Powelltown) were charged with a number of offences under the *Occupational Health and Safety Act 2004* (the OHSA).
7. On the 23 August 2011, Powelltown pleaded guilty to charges under section 21(1), 21(4) and 23(1) of the OHSA (on the basis that the breach was not causative to Mr Dickson's death) and were released on two 12 month undertakings without conviction, with a combined monetary contribution of $50,000 to be paid to the SES and CFA.
8. Mr Dickson's family were advised that non causative charges were proceeded with against Powelltown as Mr Dickson was working by himself at the time of the incident and no-one witnessed the incident.
9. I note that the agreed statement of material facts in relation to the prosecution included:
    - On the 2 October 2008, as a result of an incident at the workplace where an employee died when crushed under a stack of fallen timber in a shed, Worksafe Victoria attended the workplace. Following an investigation Worksafe investigators were unable to determine how the incident occurred. As a result of the investigation however, deficiencies were identified in the system of work relating to the stacking of racked packs of timber in the yard and in the drying sheds. The deficiencies identified in relation to the stacking of racked packs of timber gave rise to the risk of the stacked packs falling causing possible injury or death to employees.
    - Powelltown failed to provide a system of work that was, so far as was reasonably practicable, safe and without risks to health in that it failed to:
        a. Conduct an adequate hazard identification for the task of stacking racked packs of timber in the drying sheds and yard;
        b. Conduct an adequate risk assessment for the task of stacking racked packs of timber in the drying sheds and yard; and
        c. To establish an adequate system of work to stack racked packs of timber in a safe manner.
    - Powelltown also failed to provide adequate information, instruction, training or supervision with respect to the procedures to be observed in carrying out the task of stacking racked packs of timber in the drying sheds and yards.

Circumstances

10. Following consideration of the evidence, the circumstances appear to be relatively clear despite the fact that the incident was not witnessed.

11. Mr Dickson was an experienced timber yardman who had been employed at Powelltown for approximately 18 months. He was considered a very safety conscious worker and was well regarded by his co-workers.

12. Mr Dickson's usual job was to operate the forklift but he would stack timber a couple of times per week.

13. Mr Les Harley, Occupational Health and Safety Consultant engaged by the Victoria Workcover Authority to assist with the investigation into Mr Dickson's death, found the following:

    [Mr Dickson] *had been placing packs of hardwood timber planks into stacks for drying in bay 7 of the open sided canopy with a Komatsu forklift truck.*

    He had placed three stacks in position and had left the forklift to place several pieces of timber on the ground in front of the last stack.

    It appears that the last stack toppled forward trapping him beneath the planks.

    The area where the stacks are placed was uneven, packed soil and rubble.

    At the time of the inspection there was evidence of rain puddles around the stacks indicating poor drainage.

    It is presumed that the stack that fell was approximately the same height as the adjacent stacks which consisted of six packs of timber approximately 1.3m high teg. In excess of 7m. [1]

14. I can find no evidence to suggest that Mr Dickson behaved in a manner which contributed to his own death.

Remedial Action by Powelltown

15. Following the Mr Dickson's death, Powelltown introduced many changes including new forklift and stacking procedures, a reduction from 6 metre stacking, documentation and codification of workplace procedures and records with respect to employee accreditation.

16. I sought further information in relation to the prevention activities undertaken by Powelltown and any changes in the Victorian industry more generally. I was advised by Worksafe Victoria (referred to in my finding as Workafe) as follows:[2]

    Powelltown's system of work now requires employees to conduct a visual assessment of stacks, and implements control measures for the hazard of being struck by a falling stack. The new procedure also includes directions to employees, requiring them to variously fill pot holes and wheel ruts with crushed rock and then ensure they are graded level; ensure all bearers are square and placed on stable ground, directly below each row of racking sticks; ensure stacks are not higher than 4 times the width of any Pack.

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[1] Pages 5 and 6 of the Statement of Mr Les Harley

[2] Letter dated 6 September 2012 from Worksafe Victoria

17. In relation to broader industry changes I note the Worksafe publication dated 1 February 2009: '*Timber processing – stacking timber for drying*' which specifically refers to the circumstances of Mr Dickson's death and covers ground stability, bearers, stacks, monitoring and inspection of stacks as well as that the height of a stack is to be no more than 4:1 ratio.

18. I was advised that following Mr Dickson's death, Project 181 was developed by Worksafe which employed a 'zero tolerance' to the process of stacking timber for drying by operators in this industry.

Worksafe Victoria inspection on 6 August 2008

19. A Worksafe Inspector conducted an inspection of Powelltown Sawmills on 6 August 2008, approximately 8 weeks before the incident. Relevant information from the Inspection Report included:

    '*I visited your workplace in relation to a service request phoned into Worksafe. Where it had been alleged that there was stacked timber 6 meters high and children have been observed playing at the saw mill. I met with Steve Bedggood and explained the nature of the service request. He explained that the workplace had recently been visited by the Shire of Yarra Ranges based on a complaint. A walkthrough was conducted within the timber storage area I observed that there were racks of timber stacked 5 high. The approximate height was 5 meters. It was stated by Steve Bedggood that the height of the racks has been reduced over the last 3 months.*'

20. I note that the Inspector did not form the opinion that the situation required immediate action, that is, neither a prohibition notice or an improvement notice was issued.

Mention hearing

21. A mention hearing was convened on 14 December 2012 to help me understand the nature of the Worksafe Inspection in the context of Mr Dickson's death and whether the Inspector had observed the shed where Mr Dickson had died. Mr Dickson's family were in attendance at the mention hearing and raised many concerns including the manner in which the timber was stacked and the preventable nature of Mr Dickson's death.

22. I sought submissions from both Worksafe and Powelltown specifically regarding the Worksafe Inspection. I note the following from those submissions.

    - Powelltown said that the process of height reduction did not initially extend to stacks in the shed at the site but was only extended to include the shed following the death of Mr Dickson;
    - Worksafe said that the lack of fencing to prevent access to the workplace by children and other members of the public was the main reason for the visit to the workplace on 6 August 2008 and '*was the focus of the visit*'; and
    - Worksafe said that the inspector '*only observed stacks of timber that were outdoors in the open. He did not make any observations of the shed or of timber stacks within the shed.*'

23. Worksafe submitted that the Inspection did not include the shed area. I sought and obtained a statement from the Worksafe Inspector and he said: *There are numerous sheds at this site*

and I do not specifically recall entering a shed area and conducting an inspection of the timber stacks in that area.

24. I make the following observations. The Worksafe prosecution related to practices in the 'drying shed and in the yard'. Powelltown relied on the absence of action by the Inspector during that visit as part of their plea in mitigation.[3] That is, Worksafe did not think the conditions at the workplace were such that they posed an immediate risk. I note that no party (either Powelltown or Worksafe) clarified during the prosecution that the Inspection did not include the drying shed where Mr Dickson died. It is clear that the presiding magistrate relied upon the Inspection and its outcome during sentencing.[4]

25. I note that Mr Dickson's family remain perplexed about the course of the Worksafe prosecution and in particular, why causative charges where not proceeded with.[5] In this context, I note that they were not invited to make a victim statement for the purpose of sentencing. I sympathise with the family in this regard and for their loss.

26. However, after giving consideration to my statutory functions under the Act and the remedial activities undertaken by Powelltown subsequent to Mr Dickson's death, I could not identify a legitimate coronial purpose likely to be served by holding an inquest.

Was Mr Dickson's death preventable?

27. As with all coronial findings, the standard of proof is the balance of probabilities.[6] A brief of evidence was available to me which had been prepared for the Worksafe prosecution which included numerous statements from Worksafe inspectors as well as consultants who provided their opinions on this matter. I have also had the benefit of photos which were taken at the time of Mr Dickson's death. I further note that Powelltown indicated to Worksafe that '*work was about to be done*' to reduce the heights of stacks at the site (not the shed area) on 6 August 2008, approximately 8 weeks before Mr Dickson's death. In addition, I note Mr Dickson's record as a safety conscious worker.

28. Mr Dickson's family say that his death was preventable. After considering all the evidence, I agree and concur with the presiding magistrate's observations: *'Just looking at the photos from a lay person's perspective, they're set very high. It seemed obvious to me that they could fall over, and when you look at them they're enclosed, they were leaning up against each other…'.*

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[3] Mr Ray: *But the point about that Your Honour is that in the event of an immediate perception or concern or risk about health and safety, one of the immediate tools for an inspector is to issue a prohibition notice or indeed an improvement notice and that was not done. It confirms the perception that at that time (A) that there was work about to be done to deal with it and (B) it was not viewed as a significant departure.*

[4] Magistrate Vandersteen: *The deficiencies in the workplace were touched on by a Workcover inspector in August of 2008. However I accept given the tenure of the document tendered to me by Mr Ray that those concerns were not so urgent as to otherwise justify a prohibition order or a penalty improvement notice being served on the accused.*

[5] Letter dated 5 June 2013 from Mr Mark Dickson

[6] A coroner applies the principles from *Briginshaw v Briginshaw* (1938) 60 CLR 336

Findings

29. Having considered all the evidence I find that Mr Philip Stanley Dickson born on 18 October 1949 died as a result of 1(a) Multiple Injuries.

30. I find no evidence to suggest that Mr Dickson contributed to his death.

31. I further find that the death of Mr Dickson was preventable.

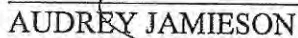
Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that the following be published on the internet:

Findings into death without inquest

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

- **Ms Patricia Ingram**
- **Mr Mark Dickson**
- **Coronial & Prevention, Enforcement Group, WorkSafe Victoria**
- **David Cantanese, Lander & Rogers**
- **Magistrate Jack Vandersteen**

Signature:



AUDREY JAMIESON

Date: 6/09/2013