CITATION: *Inquest into the death of Corey Leigh McConville* [2001] NTMC 40

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	9921991 143/99
DELIVERED ON:	23 May 2001
DELIVERED AT:	Darwin
HEARING DATE(s):	17, 18, 19 January 2001
FINDING OF:	Ms Elizabeth Morris, Deputy Coroner

CATCHWORDS:

CORONERS -- INQUEST
Transport safety – Fatigue management

REPRESENTATION:

Counsel:

Assisting:	Mr Jon Tippett
Titan Bulk Transport Pty Ltd	Mr Ralph Soulio

Solicitors:

Titan Bulk Transport Pty Ltd	Cowell Clark

Judgement Category Classification:	B
Judgement ID Number:	[2001] NTMC 40
Number of paragraphs:	50
Number of pages:	13

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

9921991

In the matter of an Inquest into the death of

COREY LEIGH McCONVILLE
ON 26 SEPTEMBER 1999

FINDINGS

(Delivered 23 May 2001)

Ms Morris:

THE NATURE AND SCOPE OF THE INQUEST

1. Corey Leigh McConville ("the deceased") died at around 02:30hrs on the 26th of September 1999 as a result of injuries received when his prime mover and trailer rolled 84 kilometres west of Timber Creek. At the time of his death he was driving a Kenworth prime mover, which was attached to a cement tanker, on behalf of his employer Titan Transport.

2. Section 12(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest was held as a matter of discretion pursuant to s15(2) of the Act.

4. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> (1) A coroner investigating -

(a) a death shall, if possible, find -

i) the identity of the deceased person;

ii) the time and place of death;

iii) the cause of death;

iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*;

v) any relevant circumstances concerning the death.

5. Section 34(2) of the Act operates to extend my function as follows:

> A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.

6. Furthermore, section 35(1) and (2) state:

> (1) A Coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A Coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

7. The public Inquest in this matter was heard at the Darwin Magistrates Court on the 17th, 18th and 19th of January 2001. Counsel assisting me was Mr Jon Tippett of James Muirhead Chambers. Mr Ralph Soulio of Murray Chambers, Adelaide, sought leave to appear on behalf of Titan Transport Pty Ltd. I granted leave pursuant to s40(3) of the Act.

8. During the Inquest documentary evidence was tendered, and six witnesses were called.

9. This evidence enables me to make the following formal findings as required by the Coroner's Act:

FORMAL FINDINGS

(a) The identity of the deceased was Corey Leigh McConville, a Caucasian male born on the 29th of April 1974 at Warracknabeal, Victoria.

(b) The time and place of death was on the 26th of September 1999 at 0230hrs on the Victoria Highway, 84 kilometres west of Timber Creek.

(c) The cause of death was multiple injuries from a motor vehicle accident.

(d) The particulars required to register the death are:

1. The deceased was a male.
2. The deceased was of Caucasian Australian origin.
3. The death was reported to the Coroner.
4. The cause of death was confirmed by post-mortem examination.
5. The death was caused in the matter described in paragraph (c) above.
6. The pathologist viewed the body after death.
7. The pathologist was Dr Michael Anthony Zillman of the Royal Darwin Hospital.
8. The father of the deceased is Gary Keith McConville and the mother of the deceased is Beverley Joy McConville (nee Argus).

9. The usual address of the deceased was 9 Gwyn Court, Driver in the Northern Territory of Australia.

10. The deceased was employed as a road train driver.

The deceased

10. The deceased came from the rural background of Warracknabeal in Victoria. He had long held ambitions of working driving trucks and machinery, especially road trains. He met his partner, Melinda Broe, in 1990. For the first five years of their relationship they lived together in Warracknabeal. They then moved to Alice Springs in 1994, where they resided for three years.

11. The deceased did not use drugs, either for recreation or for his employment. He was no more than a social drinker, and did not drink in the workplace, when he had to work or when he returned from a late night drive. He had a history of being an enthusiastic and committed worker.

12. It was in Alice Springs that the deceased obtained his road train licence. He mainly worked as a delivery driver, but occasionally did long hauls for Bulls Transport as a second driver. The couple decided to move on to Darwin, primarily in order for the deceased to obtain employment driving the larger road trains, but also to be closer to the sea and recreational fishing.

13. In 1997, after moving to Darwin the deceased obtained his Dangerous Goods Licence. He obtained employment with Toll Transport. The work was casual and involved the delivery of fresh goods in and about the urban area. He then moved on to work for NT Enviro Care, which involved long haul work to Adelaide, Mt Isa and Mataranka. During this employment he started driving double and triple trailers. These were mainly day trips of 10-14 hours in length. Occasionally he would do a trip of several days.

14. On the 23rd of August 1999 the deceased commenced work for Titan Bulk Haulage ("Titan"). He was keen to work with a company that had a "tri-drive" truck (a prime mover with three wheels on each side of the bogey). In 1999 Titan had their head office in Adelaide, but also maintained an office in Darwin.

15. This job required long haul work, with the deceased under the impression that there was a system of employment of one week on and one week off. It would appear from the evidence that if this system existed, it was not strictly enforced. He was employed as a "casual", but from commencement of duties to his death, the deceased in effect worked like a permanent employee. (T: 80)

16. The deceased had five days off between Tuesday the 7th of September and Sunday the 12th of September 1999. Between the 12th and the 17th of September he drove the Darwin – Mataranka – Jabiru run, working every day. Ms Broe's recollection was that the deceased also worked on the 18th and 19th of September. However the fuel monthly reports (Exhibit 6) indicate that the deceased did not drive any of the available three vehicles on those two days. On Monday the 20th, the deceased spent the day in the yard of Titan, cleaning up and washing the trucks.

17. On Tuesday the 21st of September the deceased did not work. After seeing a movie that night, the deceased and Ms Broe arrived home at about 11 or 11.30pm. The next day Ms Broe gave evidence of a conversation she had with the deceased, where he informed her that he had been called in to work. He was to do a 15-hour run to Mataranka with a load of waste oil. The deceased returned home at about 12.30am on Thursday morning the 23rd of September 1999.

18. Later that same day the deceased set out again for Mataranka, and returned home at 1.15am on Friday the 24th of September. He then left for work again at 7.30am that morning. He later rang Ms Broe and informed her that

his load was not ready, and he would not be leaving until about 2.00pm that day for Mataranka. He subsequently returned home from the run at 1.00am on Saturday the 25th of September.

19. Ms Broe observed upon his return that he appeared sleepy and exhausted. The deceased told her that he was "stuffed". He also told her that he had to work again that day, driving a run from Darwin to Mt Isa via Kununurra. He left for work at about 7.30am. He later returned home to pack his gear for the trip. Ms Broe observed that the deceased appeared pale and looked unwell. After some shopping they returned home together to watch some of the AFL grand final. The deceased left home at 3.00pm to go to work.

20. The deceased commenced driving out of Darwin at approximately 4.00pm. Records indicate that he refuelled his truck at Katherine Petroleum Depot at 7.50pm that evening. He then commenced the leg of the journey to Kununurra.

Relevant circumstances concerning the death

The accident

21. Brevet Sergeant David Hutchinson, of the Timber Creek police station investigated the accident causing the deceased's fatal injuries. From his investigations and observations, and the evidence produced at the Inquest, I am able to find the following facts:

22. The accident occurred at around 1.30am on Sunday the 26th of September. It took place at a point 370km from Katherine and 84 km west of Timber Creek. The road there is a dual lane bitumen Highway in good condition. It is well marked, and the accident occurred on a straight east/west stretch of the roadway with unrestricted views in both directions. The road surface was dry and traffic was light. The night was dark with little moon, but no smoke or fog in the area.

23. The road train has travelled along the Highway, and then for a distance of about 70 metres along the embankment on the right hand side of the road. It crossed a small drain before striking a built up station access track. It then became airborne for 20 metres, before returning to the ground and skidding for 40 metres before coming to rest. The prime mover came to rest on its right side. The bulk trailer jackknifed on its left side with the top of the trailer crushing the roof of the prime mover. The two units remained connected at the coupling.

24. There was no evidence of animal tracks or foreign material on the road, which may have caused the driver to take evasive action.

25. The first person on the scene was Robert O'Brien, who stopped, heard the deceased calling for help, and subsequently spoke to him. The deceased was clearly trapped in the vehicle. Mr O'Brien could not see the deceased, but heard him say that his hand was crushed, and he requested Mr O'Brien go for help. Mr O'Brien did so, eventually reporting the accident to a Department of Primary Industries officer at the West Australian border, who alerted police.

26. The second person on the scene was Mr Klayton Robb, who gave evidence before me. He arrived at about 2.00am and saw the rolled truck. He found the deceased, still trapped, and enquired about his injuries. The deceased was able to describe those injuries. Mr Robb asked the deceased:

> "How did the accident happen, did you fall asleep?"

To which the deceased replied:

> "Yes".

27. Mr Robb considered various ways of trying to get the deceased out. He found out information in relation to the truck from the deceased. Unfortunately due to the heavy nature of the vehicle, Mr Robb could not see any way of extracting the deceased. Several other passers-by also stopped,

but were unable to assist. Mr Robb continued to talk to the deceased to comfort him and let him know that someone was there. Initially the deceased answered Mr Robb, but after half an hour his response time lengthened and his words began to slur. At approximately 2.30am the deceased stopped talking. I find that he passed away around that time. Mr Robb remained at the scene.

28. At about 4.00am a nurse from Timber Creek arrived, and shortly thereafter, emergency services and the police.

29. I find that Mr Robb was a credible and reliable witness. He gave his statement to the Katherine police early that morning after arrival in Katherine. Whilst it is admitted that the suggestion of falling asleep was given to the deceased, I agree with Counsel Assisting's submission that:

> In the context of all the evidence in this case it is the only evidence that provides a satisfactory explanation as to why the accident occurred in the place it occurred, in the conditions it occurred, and in circumstances where no external cause or mechanical cause can be advanced to explain the movements of the vehicle on the roadway immediately before the accident took place. (T: 145)

30. I find on the balance of probabilities that this accident was caused because the deceased, as the driver, fell asleep or dozed at the wheel of his prime mover.

The evidence of fatigue

31. Evidence was called at the Inquest from Professor Andrew Dawson, a recognised expert in the field of fatigue and fatigue management, especially in the transport industry. Neither Professor Dawson's expertise nor his evidence were called into question at the Inquest. Professor Dawson analysed the work schedule of the deceased from the material provided.

32. On the material available to Professor Dawson, he was able to conclude that the deceased's level of fatigue at the time of the accident, in terms of an

equivalent blood alcohol reading, was between .06 and .09%. He describes the work schedule as "extremely onerous" (T: 98). Professor Dawson further comments;

> The bottom line is that if you work these trip schedules, then your capacity to get sufficient sleep to be able to operate a vehicle safely, is pretty minimal. I mean I wouldn't be happy in an organisation to see an individual working these sorts of schedules. And that's particularly in view of the case that this is the week off, let alone the week that they're meant to be on. So from my experience this would be completely outside of the limits of what would be an occupational health and safety or the duty of care of an employer to provide a safe system of work. (T: 98)

and

> If you then follow the trip that was scheduled but did not complete, then fatigue levels experienced at the peak in that trip would have gone up to around about 127 and that's so far off the scale than I'm absolutely flabbergasted. (T: 99)

33. Professor Dawson defines fatigue as "reduced levels of alertness", a "general decline in cognitive function to a point that makes it inconsistent with driving in a safe manner." (T:99)

34. Professor Dawson commented on a prescriptive model and a generalist model of fatigue management. Personally he favoured the second model as it provides for flexibility of organisations to manage in a way that is consistent with their particular operation. However, along with that flexibility comes the responsibility and potential liability if a company has failed to exercise their responsibilities under that framework.

The management of fatigue

35. The evidence of the Titan system of fatigue management came from Mr Jan Bennett. At the time of the death, Mr Bennett was the Operations Supervisor, and had been for some 18 months. Prior to employment with Titan he had worked at Shell in a similar position. He confirmed that the

deceased was employed as a "casual" driver, rather than a permanent one. Whilst Ms Broe recalls the deceased was meant to be following a week on week off arrangement, Mr Bennett stated in his evidence that it depended on customer demand, with lots of peaks and troughs, as the deceased was a "casual". (T:44)

36. The instructions given by Titan were to "follow the code of conduct in the book" (T:41) This was referring to a publication by the Northern Territory Government called "Road Transport Fatigue Management Code of Practice" (the Code). (Exhibit 5) Mr Bennett stated in his evidence that:

> "He was issued with the little pamphlet that the NT Government puts out, the same as the other drivers and all the trucks had them in it." (T:41)

It is interesting to note that in a letter from the Director of Road Transport to Northern Territory transport operators, dated the 9th of October 2000, (after the death of the deceased) Mr Sinclair states:

> "It should be noted that putting the code in the glove box of the truck does not constitute fatigue management." (Exhibit 15)

37. Mr Bennett said that monitoring was done by building into a distance a minimum of 6 to 8 hours break. There was no roster system. The trips made and kilometres covered were recorded in manifests. Fuel sheets for each vehicle were also kept. This appears to be the only evidence of a fatigue management system by the Company.

38. The vehicle provided by Titan for long haul work had an air-conditioned cabin and sleeper cabin. Mr Bennett pointed out that a driver could stop and have a rest wherever they felt the need. There was an expectation that drivers would manage their own fatigue within the work schedules expected of them. However as Counsel assisting raised with me in his closing submissions, the deceased's age and enthusiasm probably meant that he was prepared to extend himself in circumstances where he may have been

exposed to risk in order to get the job done to the satisfaction of his employer. (T: 141)

39. Evidence was taken from Mr Anthony Sinclair, Director of Road Transport, Department of Transport and Works, regarding the introduction of the voluntary code of practice.

40. He gave evidence of the development and adoption of the Code and that it was eventually gazetted on the 27th of August 1998. A code of practice was adopted, as opposed to a regulated driving scheme currently operating in most other States, in order to cater for the flexible requirements of long haul driving in the Northern Territory. The Code represents a standard by which compliance with the Work Health Act may be determined. Compliance with the Occupational Health and Safety regulations of the Work Health Act are mandatory, unlike the Code, which is voluntary.

41. In a survey conducted by the Department (after the death of the deceased) it was found that whilst most operators were aware of the need to manage fatigue, many needed and requested assistance in doing so.

42. The Department of Transport and Works, the Work Health Authority and the local branch of the Australian Trucking Association are now jointly developing draft systems for the adoption by operators to enable them to meet their occupational health and safety obligations. These include systems for owner-operators, as well as larger companies.

43. Mr Sinclair, in his letter to the Territory Coroner (Exhibit 12), concludes:

> "Driver fatigue is a significant issue for remote and regional areas of Australia including the Northern Territory and it is important that individual operators and drivers take their role in managing fatigue very seriously."

44. There is little evidence before me, that at the time of the deceased's death, Titan did in fact manage fatigue well. Certainly there were none of the Code of Practice suggested records for their management of fatigue.

45. Mr Soulio, on instructions from Titan made submissions that the voluntary code is expressed in far too general terms, and creates a situation that misleads both operators and drivers. That it fails to provide sufficient guidance to any operator or to any driver as to the way in which the process is to be carried out. (T: 154) However, apart from the matters raised in evidence by Mr Bennett, it appears that Titan did little further than pass on the Code (and the responsibility) to their drivers.

46. Even where the Code does suggest specific guiding principles, such as:

> A driver where possible should be given appropriate time to plan and prepare for a working period involving long shifts;

and

> Unfamiliar or irregular work rosters should be avoided. (Exhibit 5: 11-12)

These factors did not play a significant role in the arrangements made by the company for the trip.

Conclusions and Recommendations

47. Given the evidence of this Coronial Inquest I make a recommendation pursuant to s 35(2) of the Act, that the Attorney-General refer the circumstances of this case to the relevant Minister for the Work Health Authority for their consideration and investigation with regard to the breaching of occupational health and safety provisions.

48. That in order to achieve compliance, the voluntary industry code of conduct be made mandatory and subject to strict auditing by regulatory authorities.

49. That the Department of Transport and Works, as a matter of urgency, continue to assist transport companies with the development of fatigue management plans and strategies and training.

50. I commend the actions of those who assisted the deceased, especially of Clayton Robb, who humanely remained with and comforted the deceased by his presence and words. Mr Robb is also commended for his civic mindedness in attending at Katherine police station and providing a detailed statement, despite what must have been his own fatigue.

Dated this 23rd day of May 2001.

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Elizabeth Morris

DEPUTY CORONER