SUPREME COURT OF QUEENSLAND

CITATION:	*Thomas v Trades & Labour Hire Pty Ltd (in liq) & Anor* [2016] QCA 332
PARTIES:	**GRANT RUSSELL THOMAS** (appellant) **v** **TRADES & LABOUR HIRE PTY LTD (IN LIQ)** ACN 084 671 429 (first respondent) **GOLD COAST CITY COUNCIL** (second respondent)
FILE NO/S:	Appeal No 10006 of 2015 SC No 9892 of 2012
DIVISION:	Court of Appeal
PROCEEDING:	General Civil Appeal
ORIGINATING COURT:	Supreme Court at Brisbane – [2015] QSC 264
DELIVERED ON:	9 December 2016
DELIVERED AT:	Brisbane
HEARING DATE:	28 April 2016
JUDGES:	Morrison and Philippides JJA and Flanagan J Separate reasons for judgment of each member of the Court, Philippides JA and Flanagan J concurring as to the orders made, Morrison JA dissenting
ORDER:	**The appeal is dismissed.**
CATCHWORDS:	TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – DUTY OF CARE – REASONABLE FORESEEABILITY OF DAMAGE – where the appellant was a truck driver employed by the first respondent – where the appellant's services were contracted to the second respondent – where the appellant sustained serious injuries during the course of his work as the driver and operator of a tip truck when the tailgate of his tip truck fell and landed on his foot – where the appellant submitted that the trial judge erred in finding it was not reasonably foreseeable that a driver may be at risk of injury as a consequence of damage caused to a tailgate hinge through use of incorrect tipping procedures – whether the respondents owed the appellant a duty of care to avoid risk of injury when discharging loads from his tip truck during the course of his employment TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – STANDARD OF CARE – PARTICULAR PERSONS AND SITUATIONS – OTHER CASES – where

the appellant was a truck driver employed by the first respondent – where the appellant's services were contracted to the second respondent – where the appellant sustained serious injuries during the course of his work as the driver and operator of a tip truck when the tailgate of his tip truck fell and landed on his foot – where the appellant submitted that if a risk assessment of the tipping operations had been taken it would have indicated that it was necessary to devise and implement a procedure to instruct truck drivers as to the type of load that could be discharged under the tailgate of the truck swinging on its horizontal axis – where the appellant contended that drivers should have been instructed that items larger than 300 mm in diameter should not be tipped under the tailgate – where there was no submission that the respondents' instructions for taking steps once there had been damage to the tailgate were inadequate – whether the respondents breached their duty of care in failing to devise, implement, maintain and enforce a system where drivers were specifically instructed to tip under the tailgate if the material in the tray was solid and less than 300 mm in diameter

TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – DAMAGE – CAUSATION – where the appellant was a truck driver employed by the first respondent – where the appellant's services were contracted to the second respondent – where the appellant sustained serious injuries during the course of his work as the driver and operator of a tip truck when the tailgate of his tip truck fell and landed on his foot – where the trial judge found that the injury was caused by the appellant pushing the damaged tailgate which resulted in it falling – where the appellant submitted that the trial judge's finding did not detract from the causative effect of the breach of duty – where the appellant made a serious and substantial error in the assessment of the size of the load – where the appellant erroneously chose an improper tipping method for a load which indisputably contained material in excess of 400 mm – whether the instruction contended for would have influenced the appellant's selection of tipping procedure – whether causation was established

Bourk v Power Serve Pty Ltd & Ors [2008] QSC 29, cited
Czartyrko v Edith Cowan University (2005) 79 ALJR 839; (2005) 214 ALR 349; [2005] HCA 14, cited
Ferraloro v Preston Timber Pty Ltd (1982) 56 ALJR 872; cited
McLean v Tedman (1984) 155 CLR 306; [1984] HCA 60, cited
Mihaljevic v Longyear (Aust) Pty Ltd (1985) 3 NSWLR 1, cited
Minister Administering the Environmental Planning and Assessment Act 1979 v San Sebastian Pty Ltd [1983] 2 NSWLR 268, cited
Parsons v JJ Richards & Sons Pty Ltd [2008] NSWCA 331, cited
Strong v Woolworths Ltd (2012) 246 CLR 182; [2012] HCA 5, cited

Thomas v Trades & Labour Hire Pty Ltd (in liq) & Anor [2015] QSC 264, approved
Wolters v University of the Sunshine Coast [2014] 1 Qd R 571; [2013] QCA 228, cited
Wyong Shire Council v Shirt (1980) 146 CLR 40; [1980] HCA 12, cited

COUNSEL: B W Walker SC, with G R Mullins, for the appellant
S C Williams QC, with J McClymont, for the first respondent
K S Howe with A J Taylor for the second respondent

SOLICITORS: McCowans Specialist Lawyers for the appellant
Quinlan Miller & Treston for the first respondent
OMB Solicitors for the second respondent

[1] **MORRISON JA:** I have had the benefit of reading the draft reasons of Philippides JA. That permits me to express my reasons in short form.

[2] I agree with her Honour's analysis and conclusions except as to one question. I have reached a different conclusion on the question of causation arising out of the failure to give an instruction as to tipping the load. In my view, the evidence accepted by the learned trial judge, and the factual findings, lead to the conclusion that an appropriate instruction would have required Mr Thomas to conduct an assessment of the load at the tipping site. He did not do that at all. However, he would have complied with an instruction to do so, with the likely consequence that he would not have discharged the load as he did on the day, but swung the tailgate out of the way.

[3] As a result I would reach a different conclusion as to the outcome of the appeal. What follows are my reasons for so concluding.

[4] Mr Dalton was the operations coordinator in the fleet branch, responsible for staff such as Mr Thomas. His evidence established that drivers would have to do an assessment of the load prior to tipping:

> "You'd have to do an assessment at the time based on what it is and say, well, … if it's big, small, tree logs, whatever, you would have to do an assessment and say, based on that, this is how I will tip that load. … Every load is different, whether it be concrete, tree logs, sand, gravel, wet sand, the area you're tipping on, the ground you're tipping on, whether it's uneven, flat, whether there's pedestrians around. All those things are changing so you've got to take that into account."[1]

> " … before the driver tipped off, they would have to look at where they were tipping and make sure it was … a safe tipping ground to do so. So they'd be doing … a form of risk assessment, looking for things such as overhead wires or electrical cables, making sure there weren't any people or public around in the tipping area. Where they were backing up, they would have to make sure there were no obstacles there and, depending on the type of material that they were tipping, would determine what, perhaps, they had to do with the tailgate."[2]

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1 AB 260.
2 AB 298.

> "You'd have to have a look at that load and how it was packed in the back of the truck … before you actually tipped it off. So you really have to do a risk assessment on that particular load."[3]

[5] That assessment of the tipping was to occur at the tipping site. Necessarily it could not be made at the point of loading, at least because (i) the driver had to stay in his cab at that point, (ii) the load could shift and change its distribution during the journey, and (iii) some elements could only be assessed at the point of tipping, such as whether the ground was even or anyone was near and potentially in harm's way.

[6] That the assessment could only be done at the tipping point was emphasised by the fact that some items might change their distribution during the process: "they could change their distribution or their loading in there, and where they may have been flat to start with, they might have been bunched up and hit the tailgate".[4]

[7] Mr Dalton reinforced that point when asked in re-examination about the particular load that day:

> "If you assume that you see in that load there it's kerb and channelling, and indeed, there's a piece one metre long, 600 millimetres wide, 250 millimetres deep, and then some other smaller items, do you still say swinging the gate was the appropriate tipping operation?---For that type of load?---Yes.
>
> And - - -?---**And that would've been picked up by a risk assessment before it tipped off**."[5]

[8] Mr Dalton said that prior to the incident there was no written procedure to have drivers do the assessment at the tipping point, and "one would be relying on the experience of the driver".[6] He was asked about Mr Gutteridge's formulation,[7] that if the load was fluid it could be tipped without swinging the tailgate out of the way, but if it was "non-fluid" the tailgate had to be swung away. He answered:[8]

> "It would very much depend on what that non-fluid load was. So as I go back to what I said, the driver would have to his risk assessment; well, is it this, that, or whatever it is?"

[9] The extent of the existing system to check that drivers were, in fact, using the correct tipping procedures was limited to the supervisor of that area doing audits or spot audits around different job sites to generally check on what was happening on job sites.[9]

[10] Mr Dalton agreed that a suitable instruction would be: if the load is fluid like sand, it can be tipped without swinging the tailgate away; if it is solid, the tailgate should be swung away, and if there's any doubt, the tailgate should be swung away.[10]

[11] Mr Dalton also gave evidence as to the likelihood of Mr Thomas following instructions:[11]

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3 AB 300.
4 AB 299.
5 AB 317; emphasis added.
6 AB 301.
7 Ex 17, page 27; AB 1010.
8 AB 302.
9 AB 271.
10 AB 313.
11 AB 301.

> "He was a good worker?---Yes. He was.
>
> He was responsible?---Yes. He was.
>
> He was always reliable and on time?---Yes.
>
> He always carried out his pre-start checks?---I would have to go back and check all the paperwork. I – I don't see all those things on – on a daily basis.
>
> But there's no suggestion that Mr Thomas would not follow instruction when given?---No, I don't believe that to be the case."

[12] Mr Thomas pleaded that the relevant breach of duty was because no instruction had been given "that the tailgate should be swung about a vertical axis when the material size is greater than 300 millimetres for solid material rather than swung on a horizontal axis".[12]

[13] The response to that pleading was to deny such an instruction was necessary, and essentially rely on the fact that Mr Thomas knew the correct procedure for tipping anyway.[13]

[14] However, as will become apparent, the parties litigated the question of what the appropriate instruction should have been in a way not confined to the pleading.

[15] The learned trial judge found these facts relevant to what occurred:

(a) during the loading process Mr Thomas looked at the pieces being loaded, using his rear view mirrors and whilst he was still in the cab;[14]

(b) at that time he decided to discharge the load under the tailgate;[15]

(c) once the truck was fully loaded he got out of the cab and wound a tarpaulin across the load;[16] and

(d) at the tipping site he wound the tarpaulin back off the load; in doing so he did not walk to the rear of the truck.[17]

[16] None of that could amount to the sort of assessment of which witnesses such as Mr Dalton spoke.

[17] The learned trial judge did **not** make a finding that Mr Thomas:

(a) looked at the load once it had been loaded and before he wound the tarpaulin over it;

(b) looked at the load at all when he was at the tipping site;

(c) made an assessment, at the tipping site, of the state of the load for the purpose of tipping it out; or

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12 Amended Statement of Claim, paragraph 7.8; AB 1067.

13 Amended Defence of the Second Defendant, paragraph 7(e)(i), AB 1081; Further Amended Defence of the First Defendant, paragraph 7(n), AB 1098.

14 Reasons [15].

15 Reasons [15].

16 Reasons [16].

17 Reasons [18].

(d) was insincere or dishonest when he said that the load contained pieces no greater than 300 to 400mm, that is, small enough to tip out through the tailgate.

[18] The findings in paragraph [15] above, and those which were not found, were consistent with the evidence of Mr Thomas himself. He said, as to what occurred at the loading site:

(a) "You're looking in your mirrors all the time at the backhoe so you're looking to see what the size of the material he's putting in the back and also when to move along";[18] he observed the loading from his rear-view mirrors on the side of the truck, looking at the back of the back-hoe; he saw "small pieces of concrete and kerbing", about 300 to 400 mm;[19]

(b) when cross-examined about the loading process and what could be seen:[20]

> "Did you ever get out of the truck to check what the load was?--- I could see what my load was - - -
>
> But you would've had - - -?--- - - - by looking in my mirrors when the back hoe was loading them.
>
> But the back hoe is directly behind the truck. I suggest that you would've had great difficulty - - -?---Excuse me. The back hoe is not behind my truck.
>
> I suggest your vision would've been very limited?---No. The back hoe was alongside my truck when he was loading."

(c) the truck was loaded to about eight inches down from the side of the truck;[21] and

(d) once the loading had finished Mr Thomas got out to put the tarpaulin across the load; he was too short to see inside the back of the tray.[22]

[19] At the tipping site Mr Thomas did not inspect the load again, even though he got out of the cab to wind back the tarpaulin:[23]

> "Now, that's what was suggested to you. Did you actually have to get out of the vehicle in any case, irrespective of whether you tipped by the horizontal or vertical axis?---Yes, to wind back my cover.
>
> And in that process did you have to walk to the back of the vehicle?---No. That was behind the cab of the truck … on the back of the truck."

[20] The learned trial judge's finding was that Mr Thomas saw pieces of a certain size and "**therefore** decided **at that time**[24] to discharge the load under the tailgate".[25] The two aspects of that finding are (i) that the decision to discharge the load under the tailgate was a consequence of his appreciation of the size of the pieces in the load, and (ii) the decision to do so was made at the loading site and not later.

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18 AB 47.
19 AB 47.
20 AB 90 line 45 to AB 91 line 8.
21 AB 48 line 24.
22 AB 48 lines 30-33. That is evident from Figures 47-49 in the report of Mr Kahler, AB 445-446.
23 AB 130 lines 31-36; Reasons [18].
24 That is, during the loading process.
25 Reasons [15].

[21] Those findings were consistent with Mr Thomas' evidence, namely that he decided **how** to tip at the time the material was loaded at the load site, not at the tipping site:[26]

> "And did you make a decision at that point how you were going to tip it?---Yes. Because I watched when he loaded – the back hoe loaded me. And I thought then that I won't have to swing the tail gate or the small material will go out underneath."

[22] Further, Mr Thomas gave evidence that the decision how to tip was usually made at the tipping site. However, he said that on the day in question the decision had been made at the time the truck was loaded. In the context of questions about the use of CRC lubricant on the hinges, he was asked why he had not applied it that day:[27]

> Why not?---Because I didn't think I needed to because I wasn't going to swing my tailgate at the time. I usually apply it when I am at the tip and you can see … your load you have got on the truck, you know then if you're going to … swing your tailgate, and if you don't need to swing it, you don't spray.
>
> But don't you apply the CRC before you leave?---No.
>
> No. You - you apply it out at site?---Yes. Out at the tip, thank you."

and:[28]

> "All right. And is it your evidence that you'd wait until you got on site before determining which of those two hinges you'd applied CRC to?---Yes. Once I got to the tip.
>
> All right. So you knew what you'd be doing then?---Only by … the backhoe what was loading me."

[23] Given that it was expressly put to Mr Thomas that he was lying when he said that the load consisted of small pieces,[29] it is important to note the absence of a finding that Mr Thomas' evidence about the size of the load was insincere or dishonest. No such finding was made, and instead, at Reasons [47] and [48], his evidence on that aspect was rejected. Therefore, given the finding that the actual load consisted, in fact, of larger pieces, the learned trial judge must be taken to have found that Mr Thomas was mistaken about his view of the load. Further, as can be seen above, that mistake was made at the loading site.

[24] I do not consider that the second sentence of paragraph [89] of the Reasons should be read as amounting to a finding that Mr Thomas actually knew that load was of larger sized pieces than he said. To do so would be tantamount to a finding that his evidence was insincere or dishonest, and that finding was not made. It is, in my view, a reference back to what appears in paragraph [15] of the Reasons, namely that if the pieces were greater than 400 mm the tailgate had to be swung away before tipping. In other words, it means that if Mr Thomas had known the actual nature of the load, he knew to swing the tailgate.

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26 AB 48 lines 9-11.
27 AB 117 lines 6-13.
28 AB 124 lines 39-44.
29 AB 95 line 37.

[25] Similarly, the last sentence of paragraph [97] of the Reasons cannot, in my view, be elevated to a finding that Mr Thomas actually knew the true nature of the load. It is directed to the learned trial judge's concept of the store of knowledge.

[26] The various statements by Mr Thomas after the event do not detract from that analysis. On 23 August 2010 he said: "I did not swing the tailgate as the load pieces were small ...".[30] On 5 October he said "… at the time of the incident the load contained small pieces of concrete. Therefore it did not require me to swing the tailgate".[31] Each of those statements is consistent with the findings that Mr Thomas decided, at the loading site and as a result of what he saw (but wrongly appreciated), to tip under the tailgate.

[27] Further, the learned trial judge made no finding as to what instruction would have been reasonable to give. That issue was dealt with in this way:[32]

> "[80] Evidence was received at trial from a number of witnesses as to an appropriate instruction that could have been given to a driver such as Mr Thomas regarding when to discharge a load under the tailgate swinging on its horizontal axis and when to swing the tailgate out of the way. For example, Mr Kahler expressed the opinion that the tailgate should be swung in any case were the load consisted of solid material over 200 to 300 millimetres in size, but Dr Grigg thought that 300 millimetres would be "getting beyond the limit". An engineer employed by the Council, Mr Gutteridge, would have taken a different approach. In a record of interview which was tendered, Mr Gutteridge expressed the opinion that a load which was capable of fluid movement (such as sand) could be discharged under the tailgate but, if the load contained any solid material, the tailgate should be swung. A risk assessment carried out by the Council after the accident resulted in the promulgation of written procedures to include a focus on these very issues, although it was perhaps not formulated as well as it could have been. This risk assessment was carried out on 6 August 2010, and the resulting revised procedures were promulgated on 11 August 2010. Subsequently, the Council carried out a more comprehensive risk assessment in December 2010, which resulted in a range of new administrative controls. Lastly, in the Amended Statement of Claim, it is pleaded that drivers ought to be instructed that "the tailgate should be swung about a vertical axis when the material size is greater than 300 millimetres for solid material rather than swung on a horizontal axis".

[28] Whilst that paragraph recited the evidence, no conclusion was reached as to what an appropriate instruction would have been. However his Honour noted Mr Dalton's acceptance of the formulation by Mr Gutteridge,[33] that: (i) if the load is fluid like sand, it can be tipped without swinging the tailgate; (ii) if it is solid, the tailgate should

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30 AB 780.

31 AB 784, paragraph 24.

32 Reasons [80]; internal footnotes omitted.

33 Reasons [80], footnote 52: "Mr Dalton agreed, when cross-examined, that a more appropriate instruction would have been similar to Mr Gutteridge's formulation."

be swung away; and (iii) if there's any doubt, the tailgate should be swung away. The passage above also noted the difference of opinion between the formulations of Mr Kahler[34] and Dr Grigg,[35] and the problems with the Council's later written procedure.

[29] The difference between Mr Kahler and Dr Grigg, to which the learned trial judge referred, was as follows. Mr Kahler thought pieces of dimensions between 200-300 mm would be the limit at which a load could be discharged without swinging the tailgate.[36] Dr Grigg's view was that 200mm was the limit.[37] However, Dr Grigg agreed that Mr Gutteridge's formulation was more conservative than that of either Mr Kahler or himself, and the "if in doubt do not swing" qualification proposed by Mr Gutteridge was one he agreed with.[38]

[30] Dr Grigg's view as to the 200 mm limit was expressed only in cross-examination and not his report or in the joint report with Mr Kahler. Mr Kahler (who gave evidence before Dr Grigg) was not recalled, and he was therefore not cross-examined on the basis that Dr Grigg's formulation of 200 mm was the appropriate one.

[31] However, all witnesses on the point were unanimous that the driver had to make an assessment of the load at the tipping site. In my view, that fact, and Dr Grigg's evidence that Mr Gutteridge's formulation was more conservative than his and Mr Kahler's, indicate that the most conservative finding that could be made as to the appropriate instruction that should have been given was that instruction formulated by Mr Gutteridge but with the qualification that the assessment had to be made at the tipping site just prior to tipping.

[32] The next most conservative finding would have been that formulated by Dr Grigg, namely that if the load must be discharged with a swung tailgate if the load consists of solid pieces greater than 200mm in any dimension, with the qualification that the assessment had to be made at the tipping site just prior to tipping.

[33] The third alternative instruction is that proposed by Mr Kahler.

[34] Given that the parties litigated the question of the appropriate direction without confining it to the pleaded instruction,[39] and no finding was made by the learned trial judge, there is, in my view, no impediment created by the fact that either of the first two instructions do not conform to the pleaded instruction. Had the learned trial judge concluded that the appropriate instruction was one of those alternatives, then it is likely an appropriate amendment to the pleading would have followed. When a pleading point was taken,[40] counsel for Mr Thomas explained that what was pleaded was "the least that should have been advised".[41] The learned trial judge accepted that the evidence of Mr Gutteridge had gone outside the pleaded case, and invited an application to amend.[42]

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34 Called by the plaintiff.
35 Called by the defendants.
36 Expressed in paragraph 2 of Section 8, and Section 9, of his report, AB 449, 450.
37 AB 241 lines 14-27.
38 AB 242 lines 15-31.
39 Mr Kahler was called by the plaintiff, and Dr Grigg by the defendants. Mr Gutteridge's evidence was sought to be adduced by both sides. The defendants were going to call him as their witness, but elected not to do so only once it was established that a *Jones v Dunkel* point would not be taken if they did not call him.
40 Only by the Second Defendant.
41 AB 329 line 1.
42 AB 328-329.

[35] Ultimately an amendment was not sought,[43] but the Second Defendant[44] relied on the evidence of Dr Grigg in answer to the contention that Mr Thomas would have obeyed "any instruction".[45] Given the matters above and the fact that the appeal was not conducted on the basis that the pleadings confined the scope of the findings, one would not be denied even now.

[36] In any event, for reasons which will become apparent, for the purpose of the resolution of this appeal it does not matter which of the three alternative findings should have been made.

[37] No finding was made as to whether, if an instruction had been given, Mr Thomas would have followed it. Instead the learned trial judge simply found that such an instruction "could not have added to Mr Thomas' store of knowledge":[46]

> "[81] Such evidence, and contentions, rather missed the point. Not only were those formulations informed by the circumstances of the subject accident, whichever one might have been adopted and then expressed in training and instructions to truck drivers prior to the accident, it could not have added to Mr Thomas' store of knowledge at the time of the accident, that is to say, that the load pictured in Mr Howard's photograph should only have been discharged after the tailgate was swung completely out of the way."

[38] To approach matters that way involves, in my respectful view, an error. Any appropriate instruction would, of course, add to the store of knowledge.

[39] The only sense in which the learned trial judge grappled with the question of whether Mr Thomas would have followed an instruction was in respect of the instruction not to approach damaged equipment:[47]

> "[85] In the end, and although Mr Dalton agreed that Mr Thomas had been a good worker, responsible, reliable and punctual and, further, believed that Mr Thomas would follow an instruction when given, the fact of the matter is that Mr Thomas knew that he ought to have swung the tailgate completely out of the way before he made any attempt to discharge the relevant load. He

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43 At least so far as the parties' written submissions reveal.

44 Whose submissions on this aspect were adopted by the First Respondent.

45 In his written trial submissions counsel for Mr Thomas highlighted the fact that the "evidence as to when a driver should tip and swing varied considerably", noting the evidence of Mr Gutteridge, Mr Kahler, Dr Grigg and Mr Dalton: paragraph 41. The submission was that the failure to have a system as described by Mr Kahler was a breach of duty, but that Mr Thomas would have obeyed "any instruction": paragraphs 42-43. The Second Defendant's written submissions in reply to that relied on Dr Grigg's evidence (paragraphs 18 and 22), and contended that "it could not be found that it is likely the [Mr Thomas] would have complied with any clearer instruction" (paragraph 23). The Second Defendant did not address what instruction should have been given, relying instead on: (i) the fact that it was "causally irrelevant" because Mr Thomas knew the correct tipping procedures (paragraph 5), (ii) no further instructions were necessary (paragraph 31), (iii) the evidence of Dr Grigg as to the tipping procedure (paragraphs 14(iii) and (xiii), 60), and (iv) submitting that "one could not say that [Mr Thomas] would have complied with any other instructions" (paragraph 71). The Plaintiff's written reply submissions contended that "An appropriate instruction" would have been in accordance with Mr Kahler's evidence, ie swing if the load is in excess of 300 mm (paragraph 22.2).

46 Reasons [81]. See also [88] and [89].

47 Reasons [85].

> also knew that he was not to approach such obviously damaged equipment as the tailgate but, to instead report the damage to the Council."

[40] Several things may be noted about that passage. First, his Honour seems to have accepted the evidence of Mr Dalton as to Mr Thomas' likely compliance. Secondly, the fact that Mr Thomas did not obey the instruction not to approach damaged equipment does not lead to a conclusion that he would not have obeyed the tipping instruction, had it been given. Thirdly, it does not amount to a finding that Mr Thomas would have ignored or not complied with such an instruction.

[41] It is true that Mr Thomas himself was not asked whether, if an instruction had been given, he would have done things differently. In my view, however, there was evidence accepted by the learned trial judge[48] from which the inference was able to be drawn, and should have been drawn, that had an appropriate instruction been given, Mr Thomas would have obeyed it. Had he looked closely at the load he would have concluded that it could not be tipped without the tailgate being swung away. Mr Thomas' own evidence about the load in question shows that to be the almost certain outcome, had he assessed the load properly.

[42] In that state of affairs, the finding should have been made that Mr Thomas would have made an assessment of the load at the tipping site. There was no finding that he did make such an assessment; to the contrary the finding was that the only assessment (flawed as it was) that he made was at the loading site. Had he made a proper assessment he would not have discharged under the tailgate. The learned trial judge found so:[49]

> "But either way, here there could be no question that Mr Thomas knew how to correctly assess the relevant load and what to do in the case of the load in question – to swing the tailgate completely out of the way before discharging it".

[43] Therefore had the appropriate instruction been given the course of events would likely have been different.[50]

[44] There was no finding that the touching of the tailgate constituted a novus actus interveniens, nor was there any such contention on appeal. In my view, a finding should have been made that the failure to give an appropriate instruction as to the method of tipping was causative (at least in part) of the injuries sustained.

[45] At trial the First and Second Defendant proposed that any contributory negligence was of the order of 50-60 per cent.[51] The Plaintiff submitted there was none. On the appeal the Defendants relied upon those submissions again.[52] In the way oral argument developed senior counsel for Mr Thomas was not asked for a submission on that issue. Therefore the parties should be heard as to the question of contributory negligence.

[46] **PHILIPPIDES JA:** The appellant, Grant Thomas, appeals against the decision of the trial judge[53] dismissing his claim for damages for personal injury brought against

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48 Mr Dalton's evidence.
49 Reasons [92].
50 *Wolters v University of the Sunshine Coast* [2014] 1 Qd R 571, [2013] QCA 228, at 591 [41].
51 First Defendant's written submissions, paragraph 16; Second Defendant's written submissions, paragraph 81.
52 First Respondent's outline, paragraph 26; Second Respondent's outline, paragraph 37.
53 [2015] QSC 264.

his employer, Trades and Labour Hire Pty Ltd (the first respondent), and against the Gold Coast City Council (the second respondent), who for several years had contracted with the first respondent for the appellant's services.

[47] The claim arose out of a workplace accident on 2 August 2010 when the appellant, who was 56 years of age, sustained serious injuries during the course of his work as the driver and operator of a tip truck when the tailgate of his tip truck fell and landed on his foot. At trial, both liability and quantum were in issue. While deciding the question of liability against the appellant, the trial judge properly went on to consider quantum and assessed damages at $630,000.

The cases run at trial

[48] The case advanced at trial was summarised by the trial judge as follows:[54]

> "The case advanced on behalf of [the appellant] was that the [the respondents] failed to conduct a risk assessment of the tipping operations and that, had such an assessment been carried out, it would have revealed that it was necessary to:
>
> (a) [firstly] have in place a maintenance and inspection regime to identify structural defects in and around the tailgate and its component parts;
>
> (b) [secondly] provide proper training and instructions to truck drivers as to the taking of appropriate steps once there had been a failure of plant or equipment and, in particular, to train and instruct truck drivers that they should not approach damaged plant or equipment or to attempt to repair such damage themselves; and
>
> (c) [thirdly] devise and implement an appropriate procedure to direct truck drivers as to the type of load that could be discharged under the tailgate swinging on its horizontal axis."

[49] The trial judge noted that:

(a) As to the first matter, the maintenance and inspection regime, it was contended that a focus on structural defects would probably have identified the cracked hinge pin prior to the happening of the accident.[55]

(b) As to the second matter, the proper training and instructions, it was contended that "had [the appellant] been instructed not to approach the tailgate in a damaged state, it is probable that [the appellant] would have followed that instruction".[56]

(c) As to the third matter, the appropriate discharging procedure, it was alleged that had there been a procedure in place to direct drivers "as to the type of load that could be discharged under the tailgate swinging on its horizontal axis, [the appellant] would probably not have chosen that method but, instead, swung the tailgate on its vertical axis completely out of the way and, thereby, the accident could have been avoided".[57]

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54 [2015] QSC 264 at [9].
55 [2015] QSC 264 at [10].
56 [2015] QSC 264 at [10].
57 [2015] QSC 264 at [10].

[50] The respondents' case was outlined as follows by the trial judge:[58]

> "The [respondents] ran a joint case on liability or, at least, their approach was the same. It was to contend that [the appellant] adopted the incorrect tipping procedure for the particular load in question and that this caused the hinge to fail. The [respondents] further alleged that, when the tailgate was still attached to the tray by the latch at the top of the tailgate on the driver's side of the truck, [the appellant] pushed it, with the immediate consequence that the tailgate fell from the latch and landed on his left foot. The [respondents] otherwise maintained that the crack in the hinge pin was not reasonably detectable and that the system of work in place at the time of the accident was adequate. As to the allegations that the training and work instructions (including written procedures) which had been provided to [the appellant] were deficient, it was argued on behalf of the [respondents] that any such deficiencies were 'causally irrelevant' because [the appellant] was aware of both the correct tipping procedure for the load in question and what to do to keep himself from harm's way in the event that an item of equipment, such as the tailgate, was damaged."

The grounds of appeal

[51] On the hearing of the appeal, the appellant abandoned the ground of appeal going to quantum.

[52] The appellant did not pursue any argument as to the respondents having breached their duty of care by failing to have in place a maintenance and inspection regime that would identify structural defects. The grounds of appeal pursued by the appellant, as set out in his outline of argument, concerned whether there was a duty which had been breached and whether there was error in the determination of the issue of causation.

[53] The grounds of appeal as set out in the appellant's amended outline contended that the trial judge:[59]

1. Erred in finding that it was not reasonably foreseeable by the respondents that a driver, such as the appellant, may be at risk of injury as a consequence of damage to a tailgate hinge through incorrect tipping procedures and did not owe the appellant a duty to exercise reasonable care to avoid the risk of injury in the conduct of the appellant's employment in discharging loads.
2. Erred in finding that the respondents had not breached their respective duties of care to the appellant in failing to provide a safe system of work and should have found that the respondents were in breach of their respective duties by:
   (a) failing to conduct a risk assessment of the tipping operations;
   (b) failing to provide proper training and instruction to drivers as to the circumstances in which a load should be discharged onto the tailgate; and
   (c) failing to maintain and enforce the respective instructions in the workplace.
3. Failed to provide adequate reasons for rejecting the evidence of the expert engineer Roger Kahler (called by the appellant) that such a system of instruction should have been implemented.

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58 [2015] QSC 264 at [11].
59 Appellant's amended outline at [9] – [11].

4. Failed to apply the correct test in determining causation in that his Honour should have:

   (a) determined whether there was a breach of duty and, in particular, the instructions, training and follow-up directions by way of maintenance and enforcement of the safe system of work that the respondents were obliged to provide; and

   (b) having determined breach of duty and the instruction or training that should have been given, enquired as to whether the appellant would have followed such instruction, training and follow up direction and, if so, whether the accident would have been avoided.

The notices of contention

[54] By notices of contention, the respondents argued that the trial judge's decision should be affirmed on the basis that the appellant should have been found contributorily negligent as a consequence of his own conduct. It was contended that the appellant was guilty of contributory negligence within the meaning of Div 4 of the *Worker's Compensation and Rehabilitation Act* 2003 (Qld) to the extent of 100 per cent of the damages or, alternatively, that the appellant's damages should be reduced to an extent that is just and equitable.

The trial judge's findings of fact

[55] None of the factual findings of the trial judge were challenged. In order to assess the grounds of appeal, it is convenient to refer to the findings in some detail.

Findings as to the two modes of discharging loads from the tipper tray

[56] The tip truck was fitted with a tipper tray that could be raised or lowered hydraulically. Because of the configuration in the way the tailgate attached to the tray, there were two methods of discharging loads available, depending on the composition of the load in the tray. Firstly, the operator could elect to discharge the load under the tailgate swinging on its horizontal axis. Secondly, the tailgate could be disengaged on the driver's side of the tray and then swung completely out of the way on its vertical axis so as to allow for the free discharge of the load without any impact on the tailgate.[60]

[57] There were four connections between the tailgate and the tray. Two clasps secured the tailgate to the base of the tray and a latch secured the top of the tailgate on the driver's side of the truck to the tray. There was also a steel hinge assembly (incorporating a painted, steel hinge pin) connecting the top of the tailgate on the passenger's side of the truck to a corresponding point on the tray.[61]

[58] In order to discharge the load using the first method (that is, under the tailgate swinging on its horizontal axis), the two clasps securing the tailgate to the base of the tray had to be released using an internal control fitted inside the cabin of the truck. The tray could then be raised hydraulically using controls that were also located inside the cabin.

[59] The second method of discharging (swinging the tailgate out of the way on its vertical axis) was somewhat more involved. It required the driver to leave the cabin of the

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60 [2015] QSC 264 at [2].
61 [2015] QSC 264 at [3].

truck and move to the rear of the vehicle. In addition to using the internal control to release the clasps securing the tailgate to the base of the tray, the driver needed to disengage the tailgate and swing it out of the way. This was achieved by the driver walking to the rear of the vehicle in order to unfasten the latch at the top of the tailgate on the driver's side of the tray and, once unfastened, a steel pin then needed to be inserted by the driver at the bottom of the tailgate on the passenger's side of the truck to form a second, and temporary, hinge between the tailgate and the tray. The tailgate could then be swung around on its vertical axis to the outside of the passenger's side of the tray, where it would then be secured with a hook. The driver then needed to return to the cabin of the truck to operate the hydraulic hoist in order to raise and then lower the tray. When the load was fully discharged, the driver was then required to leave the cabin and reverse this procedure in order to return the tailgate to its original position.[62]

Findings as to the occurrence of the accident

[60] On the morning of the accident, the appellant drove his truck to a location where concrete curbing was dug up and the broken pieces were loaded onto the truck by a backhoe operated by Mr Hinde, with the appellant observing the process from within his truck.[63] Thereafter, the appellant proceeded to a tip where he discharged his load.

[61] The trial judge summed up the non-contentious features of the accident as follows:[64]

> "Stripped of its contentious features, the accident happened in this way. Unknown to anyone, the hinge connecting the tailgate to the top of the tray on the passenger's side was defective; there was a partial thickness crack in the hinge pin. After using the internal control to release the two clasps securing the tailgate to the base of the tray, [the appellant] was discharging a load of broken concrete under the tailgate swinging on its horizontal axis when the hinge pin broke. In consequence, the tailgate fell away, with its only remaining point of attachment with the tray being the latch at the top of the tailgate, on the driver's side of the truck. After lowering the tray and observing through the passenger's side mirror that something was amiss, [the appellant] alighted from the cabin of the truck and walked to the rear of the vehicle. As he was standing behind the tailgate, it broke away from the latch and fell onto [his] left foot …".

[62] A contentious issue at trial was whether the appellant touched the tailgate before it fell. The appellant maintained that he did not, notwithstanding evidence that he had stated to a number of persons that he had pushed the tailgate before it fell. His Honour did not accept the appellant's evidence that he did not touch the tailgate before it fell. In that regard, his Honour stated:[65]

> "… I find that, when [the appellant] walked to the rear of the truck to view the damage, the tailgate was hanging from the latch on the driver's side of the tray. No part of it was resting on the ground. Instead, the tailgate was hanging at an angle to the ground with its *only point of*

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62 [2015] QSC 264 at [4].
63 [2015] QSC 264 at [14].
64 [2015] QSC 264 at [5].
65 [2015] QSC 264 at [41] (emphasis added).

> *attachment* to the tray being the latch at the top of the tailgate on the driver's side of the truck. I find that [the appellant] took up a position behind the truck … He then pushed the bottom corner of the tailgate on the driver's side of the truck in an attempt to either push it back into position or slide it into the tray so that, if successful, he could then drive back to the [second respondent's] workshop for the assessment and repair of the tailgate. I find that [the appellant] pushed the tailgate gate deliberately and with that purpose in mind."

Findings as to the composition of the load

[63] The curbing in the load in question had a particular profile and relatively uniform dimensions in situ, being 600 mm wide, between 250 mm and 280 mm deep and up to 1.5 m long.[66]

[64] The trial judge referred to the appellant's account of "sitting in the truck alongside [the] backhoe" and "looking in [his] mirrors all the time at the backhoe" so as "to see what the size of the material" being loaded was "and also when to move along".[67] The appellant's evidence was that he saw "small pieces of concrete and curbing" being loaded. None of the concrete pieces he observed being loaded onto his truck were greater than 300 to 400 mm in length, width or depth. He therefore decided to discharge the load under the tailgate because he thought the pieces were small enough to "go out underneath".[68]

[65] The trial judge, however, did not accept that the concrete pieces discharged from the truck were as small as described by the appellant.[69] His Honour found that the pile of concrete blocks that was discharged from the appellant's truck was depicted in a photograph taken by the appellant's supervisor, Mr Howard, after the accident.[70] That pile contained many pieces of concrete substantially in excess of 400 mm in length or width which the appellant had mentioned and included at least one piece that was approximately one metre in length and 600 mm in width.[71]

Findings as to the nature of the defective hinge pin and its detectability

[66] The trial judge concluded that the partial thickness crack in the hinge occurred during manufacture.[72] There were a number of factors that told against the detection of the crack. One was that bending was the expected mode of failure of a hinge pin, not only because there had been no prior instance of a pin being broken but also because the pins were designed to be ductile. The pins could thus reasonably be anticipated to bend under stress; not to snap.[73]

Findings as to what caused the hinge pin to break and the tailgate to fall

[67] The trial judge accepted the evidence given by both the appellant's expert engineer, Mr Kahler, and the second respondent's expert engineer, Dr Grigg, that the load the

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66 [2015] QSC 264 at [43] and [47].
67 [2015] QSC 264 at [14].
68 [2015] QSC 264 at [15].
69 [2015] QSC 264 at [47].
70 [2015] QSC 264 at [44] and [48].
71 [2015] QSC 264 at [48].
72 [2015] QSC 264 at [52].
73 [2015] QSC 264 at [54]-[57].

appellant discharged immediately prior to the accident must be taken to have imposed a significant force on the tailgate, which in turn applied a large force to the hinge pin. His Honour found that the hinge pin, already compromised by the pre-existing crack, broke in consequence of this force.[74]

[68] Having found that the only point of attachment between the tailgate and the tray after discharge of the load was the latch at the top of the tray on the driver's side of the truck, his Honour considered what contribution was made by the appellant's pushing the tailgate.[75] His Honour found that there was a direct relationship between the appellant's push and the dislodgement of the tailgate from the latch. Specifically, he found that the push applied by the appellant was the disturbing force which caused the tailgate to dislodge and fall on his left foot.[76]

Findings as to the system of maintenance

[69] The trial judge found that the trucks were regularly serviced and maintained and that an appropriate inspection had taken place prior to the accident.[77]

Findings as to training and instructions

[70] A Hazard and Risk Evaluation conducted in 2008 of the activity described as "loading and unloading trucks" did not identify any hazard associated with the tailgate other than to ensure that it was closed and locked, with the safety chain engaged, before driving the truck.[78]

[71] When he commenced working with the second respondent, the appellant was "inducted into the truck". This consisted of a demonstration of the "operation of the vehicle", driving to and from a quarry with another driver and completing an induction sheet. There was no further training or refreshers, other than at monthly "toolbox meetings". Mr Howard would also conduct "spot checks" around the various sites to make sure that drivers were tipping appropriately.[79]

[72] Drivers were not given any training or instructions about how to discharge a particular load. They were expected to make their own assessment of each load in order to determine whether to discharge under the tailgate swinging on its horizontal axis and when to adopt the alternative method of swinging the tailgate on its vertical axis. They were, however, given instructions about what to do when confronted with damage to the vehicle.[80]

[73] The trial judge referred to the evidence of Mr Dalton (the operations coordinator of the second respondent's fleet) that the drivers who were employed or hired by it were already experienced and trained in the operation of the trucks and that was an essential prerequisite for the tasks which it required them to perform. Mr Howard also gave evidence that the second respondent expected all drivers to be "fully experienced" before they were engaged. The trial judge found that the appellant was employed, and then hired, as an experienced driver and operator of trucks.[81] His experience as

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74 [2015] QSC 264 at [58].
75 [2015] QSC 264 at [59]-[61].
76 [2015] QSC 264 at [62].
77 [2016] QSC 264 at [63]-[72].
78 [2015] QSC 264 at [74].
79 [2015] QSC 264 at [73].
80 [2015] QSC 264 at [75].
81 [2015] QSC 264 at [76].

a truck driver and operator could not be questioned; by the time his services were contracted to the Council, he was a highly experienced truck driver and operator.[82]

[74] On the question of whether loads should be discharged under the tailgate swinging on the horizontal axis or swung completely out of the way, his Honour noted Mr Howard's evidence was that there were "only two ways to do it", that "an experienced operator would be able to identify which way he should be tipping" and that Council "wouldn't tell an experienced operator what he should do". Such an operator should "be able to assess the situation and go ahead and perform his job".[83]

[75] The trial judge found that the appellant was well aware of the correct tipping procedures and noted, in particular, that the appellant agreed when giving evidence that he "fully well knew" when to swing the tailgate and when to tip the load under the tailgate operating on its horizontal axis. Further, the appellant agreed that he did not need to be instructed about those matters because he already knew about them through his own experience.[84] The appellant also agreed that "the requirement that drivers should make their own assessment of each load in order to determine which tipping method was used was necessary because of the variability in the composition of different loads".[85] A load might consist of boulders, rocks, metal, concrete, sand, soil, road base, logs, mulch or a mix of any of these materials. The appellant therefore agreed that there could not be a "blanket rule" regulating when to tip in a certain way. His Honour noted that Mr Dalton, Mr Howard, Mr Hinde and Mr Young (another driver) also agreed with this proposition.[86]

[76] The trial judge found that the appellant knew that, for the size of concrete blocks depicted in the photograph taken by Mr Howard, the tailgate should have been swung around to the outside of the passenger's side of the tray and not tipped under the tailgate operating on its horizontal axis. This was also the view of Mr Hinde and Mr Dalton, each of whom was shown the same photograph,[87] and was implicit in the appellant's statement to Ms Cox (a Workplace Health and Safety Inspector):[88]

> "The task of unloading of items was the normal process involved with tipping loads. However, at the time of the incident the load contained small pieces of concrete. Therefore it did not require me to swing the tailgate. Normally if it had of been larger pieces of concrete it would require me to manually swing the tailgate. By this I mean would unlatch the right side of the tailgate and swing it over to the left side to latch back to the truck."

The evidence concerning the system for discharging loads and for what to do in the event of damage

[77] The trial judge summarised the evidence as to an appropriate instruction that could have been given to a driver such as the appellant regarding when to discharge a load under the tailgate swinging on its horizontal axis and when to swing the tailgate out of the way as follows:[89]

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82 [2015] QSC 264 at [77].
83 [2015] QSC 264 at [76].
84 [2015] QSC 264 at [77].
85 [2015] QSC 264 at [78].
86 [2015] QSC 264 at [78].
87 [2015] QSC 264 at [79].
88 [2015] QSC 264 at [79].
89 [2015] QSC 264 at [80].

> "… Mr Kahler expressed the opinion that the tailgate should be swung in any case were [sic] the load consisted of solid material over 200 to 300 mm in size, but Dr Grigg thought that 300 millimetres would be 'getting beyond the limit'. An engineer employed by the Council, Mr Gutteridge, would have taken a different approach. In a record of interview which was tendered, Mr Gutteridge expressed the opinion that a load which was capable of fluid movement (such as sand) could be discharged under the tailgate but, if the load contained any solid material, the tailgate should be swung. A risk assessment carried out by the Council after the accident resulted in the promulgation of written procedures to include a focus on these very issues, although it was perhaps not formulated as well as it could have been. This risk assessment was carried out on 6 August 2010, and the resulting revised procedures were promulgated on 11 August 2010. Subsequently, the Council carried out a more comprehensive risk assessment in December 2010, which resulted in a range of new administrative controls. Lastly, in the Amended Statement of Claim, it is pleaded that drivers ought to be instructed that 'the tailgate should be swung about a vertical axis when the material size is greater than 300 millimetres for solid material rather than swung on a horizontal axis'."

[78] As to that issue, his Honour concluded:[90]

> "Such evidence, and contentions, rather missed the point. Not only were those formulations informed by the circumstances of the subject accident, whichever one might have been adopted and then expressed in training and instructions to truck drivers prior to the accident, *it could not have added to [the appellant's] store of knowledge at the time of the accident, that is to say, that the load pictured in Mr Howard's photograph should only have been discharged after the tailgate was swung completely out of the way*."

[79] In relation to the separate issue of the training and procedure in the event of damage, his Honour stated:[91]

> "As to the position that obtained in the event of the occurrence of damage, the written instructions provided by the Council to drivers prior to the accident required them to 'immediately report any problems with the vehicle/plant to the allocator and workshop reception and await instructions'. Those instructions also contained this direction:
>
> > 'Incidents and accidents involving Heavy Plant and Trucks **must be** reported immediately to your Supervisor and the Plant or Truck involved **must be** presented to Carrara Depot Insurance Personnel on your return from site.'
>
> As discussed earlier, [the appellant] was well aware at the time of the accident that he was required by the Council to report any damage to his truck to the 'office staff' and not to attempt to repair any such damage himself but to, instead, await further instructions. He also told

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90 [2015] QSC 264 at [81] (appellant's emphasis).

91 [2015] QSC 264 at [82]-[84] (emphasis in original).

> Ms Vandermaat that he was aware of the procedure to contact the office in the event of damage to the truck but said that he thought he 'could get the tailgate to fall into the tray by pushing it before [he] rang'.
>
> Although there was evidence to the effect that drivers could exercise their own discretion whether to attempt to effect minor repairs, it could not seriously be suggested that [the appellant] was entitled to believe that it was permissible for him to attempt to do anything with the hanging tailgate other than to report it to the depot office. Indeed, [the appellant] agreed that he required no directions or instructions not to touch, push or approach the tailgate when it was so obviously damaged. He agreed that it would be a 'stupid and reckless thing to touch the tailgate and push it' in those circumstances. He did not need anyone to tell him that he should be careful in that situation. In particular, [he] accepted that it would be 'silly and reckless to get in a position where' the tailgate could fall on him."

[80] His Honour's conclusions as to these two issues were stated as follows:[92]

> "In the end, and although Mr Dalton agreed that [the appellant] had been a good worker, responsible, reliable and punctual and, further, believed that [the appellant] would follow an instruction when given, the fact of the matter is that [the appellant] knew that he ought to have swung the tailgate completely out of the way before he made any attempt to discharge the relevant load. He also knew that he was not to approach such obviously damaged equipment as the tailgate but, to instead report the damage to the Council."

Determination of issues of liability

[81] Citing *McLean v Tedman & Anor*[93] and *Czartyrko v Edith Cowan University*,[94] his Honour acknowledged,[95] firstly, that, in the course of deciding whether an employer has provided a safe system of work, it is necessary to consider whether such a system was enforced and maintained and, in that regard, that the possibility of negligence, inadvertence or carelessness on the part of the employee when carrying out the work must be taken into account. Secondly, there was also, and ultimately, a question of "whether any of the alleged deficiencies in the system of work bore a causal relationship to the happening of the accident", which his Honour considered depended "on the discoverability of the crack in the hinge pin, the foreseeability that such a defect might develop, and [the appellant's] store of knowledge at the time of the accident".[96]

[82] The trial judge approached those issues in the following manner:[97]

> "… once it is appreciated that the load which [the appellant] emptied included large pieces of concrete curbing – and many of which were substantially greater in width or depth than 400 millimetres – the position, so far as liability is concerned, becomes clear. Given the

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92 [2015] QSC 264 at [85].
93 (1984) 155 CLR 306.
94 (2005) 214 ALR 349.
95 [2015] QSC 264 at [87].
96 [2015] QSC 264 at [88].
97 [2015] QSC 264 at [89]-[91].

> composition of the relevant load, [the appellant] well knew that the tailgate should have been swung out of the way. It was not. Instead, [the appellant] discharged the load under the tailgate and, as I have found, when he did so, sufficient forces were applied to the tailgate to cause the hinge pin – already weakened by the pre-existing defect – to snap through. This left the tailgate hanging at an angle, with its only point of attachment with the tray being the latch on the driver's side of the tray.
>
> Observing through the passenger's side mirror, [the appellant] saw the tailgate hanging. He knew what he was obliged to do, that is, to make contact with his supervisor to report the incident and await further instructions. [The appellant] said in evidence that, in order to do so, he needed to first take a better look. Although there was some debate during the trial as to whether such a course was permissible, [the appellant] can hardly be criticised for alighting from the cabin of the truck in such circumstances. Apart from anything else, it was necessary for him to provide an accurate report to his supervisor, and that could hardly be done based on observations made through the passenger's side mirror.
>
> However, having left the cabin of the truck, [the appellant] knew that he needed to stay well clear. The danger posed by the hanging tailgate should have been obvious to him. Indeed, when giving evidence, [the appellant] accepted that to be so. Knowing, therefore, that it was dangerous to do so, [the appellant] pushed the tailgate with the consequence that it fell on his left foot."

[83] In considering the system of work in place, his Honour commented:[98]

> "The system of work in place at the time of the accident substantially relied on the experience of drivers and operators such as [the appellant]. Although the defendants were entitled to rely on the common sense and experience of its drivers and operators,[99] criticisms can be made of such a system because on-the-job experience is variable in both quality and duration. A system of work that depends on such variables may be difficult to enforce or maintain. As against that, the variation in the composition of loads drivers were required to carry may have meant that a 'blanket rule' could not have been adequately developed.[100] But … here there could be no question that [the appellant] knew how to correctly assess the relevant load and what to do in the case of the load in question – to swing the tailgate completely out of the way before discharging it. Similarly, because of the instructions that were in existence at the time of the accident – requiring damage to equipment to be reported and for there to be no attempt on the part of the driver to repair any such damage – as well as [the appellant's] own experience and common sense, he knew not to go near the hanging tailgate.
>
> For [the appellant], it was argued that a risk assessment of the tipping operations would have revealed that it was necessary for there to have

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98 [2015] QSC 264 at [92]-[98].

99 *Bourk v Power Serve Pty Ltd & Ors* [2008] QSC 29 at [51]-[57].

100 *Parsons v JJ Richards & Sons Pty Ltd* [2008] NSWCA 331 at [35].

been in place a maintenance and inspection regime to identify structural defects, as well as training and instructions about the type of load that could be safely tipped through one of the two alternative methods. I do not agree. For the reasons earlier expressed, the expected mode of failure of the hinge pin was bending … [so that] the tailgate might be misaligned … but it would remain attached.

Furthermore, the material out of which the hinge pin was manufactured was supposed to be ductile. Although in this case the hinge pin was brittle due to a manufacturing error, in all other cases it is to be inferred that the hinge pins were sufficiently ductile to bend rather than break. It follows that, had a risk assessment been carried out prior to the accident which was focused on the hinge pins, the mode of failure would have been expected to be bending. As such, there would have been no reason to identify 'structural defects in and around the tailgate and its component parts' as a relevant, or foreseeable, risk.

For the same reasoning, it is unsurprising that, under the system of maintenance adopted by the Council prior to the accident, none of the employees assigned to the task of checking or maintaining the tailgate were alerted to (1) the possibility that a hinge pin might crack and break or (2) the need to make a close inspection of the region of the hinge pin which fractured in this case to ensure that there were no cracks. Nor would it be reasonable to expect, given the state of the Council's knowledge at the time of the accident, that an instruction to that effect ought to have been given to those employees. The maintenance and inspection procedures which were in place at the time of the accident were adequate in my view to guard against known risks. On the other hand, the crack in the hinge pin was neither to be expected nor reasonably discoverable.

It was submitted on behalf of [the appellant] that there was a foreseeable risk of a 'tailgate or hinge being damaged' by 'poor operator procedure' in 'failing to tip properly' and a similar submission was made with respect to damage to the truck. It was then submitted to have been reasonably foreseeable that, if there was not a safe system of work in place with respect to the tipping operations, drivers and other employees, including [the appellant], would be exposed to risk of injury. Although the existence of a foreseeable risk of damage to the tailgate, the hinge and, indeed, the truck may be accepted if loads were not discharged using the appropriate method, it was not reasonably foreseeable that the hinge pin would break, instead of bend, when put under stress. In the absence of a complete failure of the hinge pin through breaking, it is difficult to see how a driver such as [the appellant] could have been put in a position of danger merely because the hinge pin might bend. [However, in the] circumstances, it cannot be said that a risk of injury to a driver and operator such as [the appellant] through an entirely different mode of failure – breaking – was reasonably foreseeable and such as to give rise to a duty of care to guard against such a risk.

But, even if a duty of care did arise, [the appellant's] claim would fail in any event through lack of proof of causation. None of the deficiencies

> in the system of work alleged on behalf of [the appellant] had any causal bearing on the happening of the accident. [The appellant] knew all that he needed to know to correctly assess the load, discharge it properly and to stay well clear of damaged equipment such as a hanging tailgate.
>
> It only remains to be said that there is no suggestion in the evidence that [the appellant] was under any particular time imperative to empty the relevant load. Nor was the task he was undertaking at the time of the accident 'repetitive' or 'tedious' in the sense described in *McLean v Tedman*.[101] [The appellant] was an experienced driver and operator who made a deliberate decision to discharge the load under the tailgate swinging on its horizontal axis, rather than adopting the alternative method which he knew should have been used. He then placed himself in a position of obvious danger before making a conscious choice to push the tailgate."

The applicable legal framework

[84] There was no contest that the *Civil Liability Act* 2003 (Qld) did not apply to the appellant's claim for damages for personal injury. Accordingly, the legal framework to be applied in the claim against the second respondent is the common law, while the claim against the first respondent was regulated by the provisions of the *Workers' Compensation and Rehabilitation Act* 2003 (Qld).

[85] There was also no dispute with the appellant's submissions that the following steps were required to be undertaken in determining the content of the duty of care, whether the duty of care was breached and whether the breach of that duty caused or contributed to the injury:

1. The existence of a duty of care owed by an employer to an employee is an established category of case. It amounts to "no more than the obligation to take reasonable care to avoid exposing the employee to an unnecessary risk of injury".[102]
2. Foreseeability of risk of injury in the context of breach of duty is determined by inquiring whether it 'was reasonably foreseeable as a possibility that the kind of carelessness charged against the defendant might cause damage of some kind to the plaintiff's person or property".[103] The requirement of foreseeability that "some kind" of damage was foreseeable is an "undemanding"[104] test and the risk must not be far-fetched or fanciful.[105]
3. The employer is bound to have regard to a risk that an injury may occur because of inattention or misjudgement by the employee in performing his or her allotted task.[106] In giving content to the words of generality in the employer's duty and in determining whether a breach of it was foreseeable and, if foreseeable,

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101 (1984) 155 CLR 306.

102 *Mihaljevic v Longyear (Australia) Pty Ltd* (1985) 3 NSWLR 1 at 10-11 per Kirby P; *Ferraloro v Preston Timber Pty Ltd* (1982) 56 ALJR 872 at 873.

103 *Minister Administering the Environmental and Planning Assessment Act 1979 v San Sebastian Pty Ltd* [1983] 2 NSWLR 268 at 296 per Glass JA.

104 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 44 per Mason J.

105 *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47 per Mason J.

106 *Mihaljevic v Longyear (Aust) Pty Ltd* (1985) 3 NSWLR 1 at 12 per Kirby P; *Ferraloro v Preston Timber Pty Ltd* (1982) 56 ALJR 572 at 873.

involved so small a risk that the employer was justified in disregarding it, the employer's obligation extends to establishing, maintaining and enforcing a safe system of work and includes a duty to take account of the employee's negligence, inadvertence and carelessness in carrying out their work.[107]

4. In determining causation, the Court must consider the alleged breach of duty and, if the breach of duty is an omission, determine whether the plaintiff would have acted differently had the omission not occurred. Proof of the causal link between an omission and an occurrence requires consideration of the probable course of events had the omission not occurred.[108] As Gotterson JA observed in *Wolters v University of the Sunshine Coast*:[109]

> "As noted, in *Sabatino*, Mason P reminded, as Gaudron J had pointed out in *Bennett v Minister of Community Welfare*, that in cases of negligence by omission, a finding of liability is necessarily based upon a hypothetical inquiry, Here, as principle required, the primary judge set about such an inquiry. It was into whether the incident (and hence injury) would have been avoided if the respondent had discharged its duty of care by taking appropriate action to reprimand and counsel Mr Bradley. That the incident occurred is a historical fact. Whether it would have been avoided is not, of itself, a fact. It is a conclusion with respect to the likelihood that the incident would have been avoided had the duty been discharged. The objective of the inquiry undertaken by the primary judge was to assess the likelihood of that.
>
> The frame of reference for such an inquiry is set by reference to that which the duty of care required have been done. The inquiry is undertaken by assessing all relevant facts and circumstances from which a conclusion is then drawn as to the likelihood that the performance of that which the duty required have been done, would have avoided the incident.
>
> The integrity of the inquiry is therefore dependent upon both a precise articulation of what it is that the duty of care required and an appraisal of all relevant facts and circumstances in order to assess likelihood. A failure to articulate the former or to undertake the latter risks a miscarriage of the inquiry and a resultant lack of legitimacy in the ultimate conclusion drawn from it."

Duty of care

The appellant's submissions

[86] The appellant argued that the trial judge erred in concluding[110] that it was not reasonably foreseeable that there was a risk of injury to a driver and operator through the breakage of a hinge pin such as to give rise to a duty of care to guard against that risk. The appellant argued that the proper approach was for the trial judge to ask whether it was reasonably foreseeable that failure to provide instructions as to an appropriate tipping procedure might cause "damage of some kind to the [appellant's]

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107 *McLean v Tedman* (1984) 155 CLR 306 at 312-313 per Mason, Wilson, Brennan and Dawson JJ.
108 *Strong v Woolworths Ltd* (2012) 246 CLR 182 at [32] per French CJ, Gummow, Crennan and Bell JJ.
109 [2014] 1 Qd R 571 at 591-592 [40]-[43] (citations omitted).
110 [2015] QSC 264 at [96].

person or property". The appellant submitted that the trial judge should have accepted that it was reasonably foreseeable that there was a risk of injury to an operator if appropriate tipping procedures were not adopted.

[87] In relation to that issue, the appellant referred to the following evidence. Mr Howard (the second respondent's heavy plant supervisor) gave evidence that, prior to 2 August 2010, he was aware that there was a risk of a tailgate or a hinge being damaged by what he would describe as "poor operator procedure" in failing to tip properly.[111]

[88] Further, the appellant referred to evidence of Mr Dalton (the second respondent's fleet operations coordinator). He stated that the second respondent had 30 to 40 tippers that were likely to be working on any particular day, along with an additional 40 or 50 extra tipper trucks,[112] so that there might be as many as 90 to 100 operators at any one given time operating tippers on behalf of the second respondent. These drivers reflected a diverse range of training, backgrounds and personalities.

[89] The appellant placed particular reliance on Mr Dalton's cross-examination evidence, where it was submitted that Mr Dalton had agreed in cross-examination that it was important for the second respondent to ensure that tipping was done properly since, if it was not done properly, it might damage the truck and create a dangerous situation that was unstable and needed to be resolved quickly. He also accepted that the second respondent's employees might then be exposed to a risk of suffering injury.[113] It was submitted that Mr Dalton's evidence in this respect was not contested.

The respondent's submissions

[90] The respondents accepted that the evidence justified a finding that an incorrect tipping procedure could cause damage to the tailgate. However, it was submitted that, with respect to the hinge, if the hinge of the tailgate were damaged by an incorrect tipping procedure, there was evidence, properly accepted by the learned trial judge, that the hinge pins were designed to be ductile, so they would not break but would bend, and the tailgate would remain attached though mal-aligned.[114]

[91] The fact that the appellant suffered injury following his utilisation of the incorrect tipping procedure was due, it was submitted, to the combined result of two additional circumstances, that were the subject of unchallenged findings:

(a) The hinge pin was brittle due to a defect in the manufacturing process[115] causing a crack which was not reasonably detectable.[116]

(b) Observing the tailgate to be damaged and hanging, the appellant attempted to push it in to the tray of the truck, which conduct was not just foolhardy but a breach of the second respondent's instruction to him to report any damage to Council staff and not to attempt to repair any such damage himself.[117] Furthermore, the appellant's conduct of attempting to push the tailgate was a "reckless", "stupid" and "silly" act which he knew to be futile.[118] It could not

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111 AB 367.10-369.25.
112 AB 300.35.
113 AB 301.42-302.6.
114 [2015] QSC 264 at [93].
115 [2015] QSC 264 at [52].
116 [2015] QSC 264 at [54]-[57].
117 [2015] QSC 264 at [83].
118 [2015] QSC 264 at [84].

be said to amount to mere "inadvertence" or "carelessness". It was said that there was no evidence, nor argument by the appellant, that the respondents should have known that workers would disregard instructions and act with reckless disregard for their own safety.

[92] The respondents argued that the appellant's submission that the risk of injury to him was foreseeable would require the respondents to foresee:

(a) that an incorrect tipping procedure could result in damage to the hinges affixing the tailgate to the tray, which would result in the hinges bending, a situation in which, as the learned trial Judge found, "*it is difficult to see how a driver such as [the appellant] could have been put in a position of danger*";[119]

(b) that, contrary to past experience, and due to a manufacturing defect, the damage to the tailgate could include breakage of the hinge pin such that the tailgate would come loose from the truck; and

(c) that workers would disregard an explicit instruction not to attempt to repair the damage, and would demonstrate reckless disregard for their own safety, such that they were imperilled by the hanging tailgate.

[93] It was contended that the appellant's submission, that the trial judge should have approached the issue of whether a duty of care arose by asking whether it was reasonably foreseeable that failure to provide instructions as to an appropriate tipping procedure might cause "damage of some kind to the [appellant's] person or property",[120] was one that was broadly based.[121] There was no failure to provide instructions which was causally related to the appellant's injury – the appellant was aware of the correct tipping operations for the subject load which was, in particular, depicted in the photograph.[122] That procedure was that the tailgate should have been swung horizontally.

[94] The respondents referred to the evidence of Mr Dalton, relied upon by the appellant to support a finding that there was a foreseeable risk of injury associated with an incorrect tipping procedure, as being the following:[123]

> "It's important to the Gold Coast City Council for a number of reasons, isn't it, that the tipping be done properly? --- That's correct.
>
> It's important because if it's not done properly, it might damage the truck? --- That's possible, yes.
>
> Secondly, if it's not done properly **and the load is not properly unloaded**, it creates a dangerous situation that is unstable that needs to be resolved? --- That's possible.
>
> And once it creates a dangerous situation, it exposes the Council or Council employees or other people to a risk of suffering injury; that's fair? --- That is correct."

[95] It was submitted[124] that the passage highlighted in bold above made it clear that the question about a risk of injury was premised on the hypothesis in the preceding

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119 [2015] QSC 264 at [96] (emphasis added).
120 Appellant's amended outline at [16].
121 Second respondent's amended outline at [14].
122 See AB 580.
123 AB 301-302 (emphasis added).
124 First respondent's amended outline at [10].

question that the "load is not properly unloaded". That scenario contemplated a wide variety of risks, including the place in which the load is dumped, the way in which the load is tipped from the truck and the stability of the pile of dumped material. There was nothing in the question to elicit Mr Dalton's awareness of any risk of injury consequent upon damage to the truck caused during unloading.

[96] It was thus argued[125] that Mr Dalton's evidence did not support the contention raised by the appellant. Mr Dalton was simply giving broad based evidence, whereas it was argued that the true question was whether or not injury as a result of the hinge pin failing was foreseeable.

[97] As to Mr Howard's evidence, it was contended[126] that his statement that was relied on by the appellant did not adequately reflect what Mr Howard's evidence was. Mr Howard's evidence was referring to the risk of the tailgate being damaged with reference to it bending.[127] There had never been any failure of any hinge pins on any other occasions. He had not seen it. The evidence before the trial judge was that the appellant was aware of the correct tipping procedure, was experienced and did not need to be told as to how to tip and what method was to be used. He was employed on the basis that he was experienced and had such a store of knowledge. Mr Howard would monitor and observe people operating the trucks to ensure that tipping procedures were being correctly adopted.[128]

[98] In the circumstances, it was submitted that it should be concluded that the risk of injury to the appellant as the result of adoption of an incorrect tipping procedure was properly categorised as "far-fetched or fanciful". The trial judge was correct to conclude that the risk of injury to the driver was not reasonably foreseeable.[129]

Discussion

[99] In my view, the appellant is correct in his contention that the trial judge ought to have found that a duty of care did arise in the circumstances of the present case, as there was a reasonably foreseeable risk of injury arising from poor operator procedure in failing to have a proper system of work in place in relation to tipping procedures and proper training and instructions as to the appropriate steps to be taken in the event of damage to the truck being sustained.

[100] As to the argument that the quoted passage from Mr Dalton's cross-examination evidence does not support the finding of a duty of care, I do not consider that his evidence should be understood in the way contended for by the respondents. I do not consider that Mr Dalton's evidence should be dismissed as simply "broad based evidence". Mr Dalton's evidence indicated an awareness of risk of injury consequent upon damage to the truck caused during unloading.

[101] The foreseeability of the risk is also supported by the evidence of Mr Howard:[130]

> "If the hinges would bend because of poor tipping procedure, it may mean, of course, that the tailgate wouldn't shut after the tip?---That's

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125 Second respondent's amended outline at [18]-[19].
126 Second respondent's amended outline at [15].
127 AB 367.10-367.20.
128 AB 360.8-360.14.
129 [2015] QSC 264 at [97].
130 AB 367-368.

> not because of poor tipping procedure; it's because of poor operator procedure because they haven't actually swung the tailgate appropriately to not let it do that, and that has happened, and we reiterated it all the time, and again, through probably our continuous improvement, in some other tailgate incidents that we have – not similar to this one, but smaller trucks – where they haven't – when they haven't swung the tailgate, there's a latch that they have to put it on the side of the truck so it doesn't swing or move when they're tipping. We've now got a process in place that they have to actually padlock it off on the side, and you can't do anything till it's padlocked off. So that is how you stop the tailgate from getting caught on the ground or wherever when they're tipping, which means you don't have the problem of the hinge bending or fracturing, as it did in this case by the looks of it.
>
> In the 10 years that you have been at the Council, you have seen damaged hinges on a number of occasions?---I haven't seen them on a number of occasions. I could probably count on my hand how many I've seen, but I'm not in the repair of the machines. I'm in the – I'm sort of in the business of making sure they're on the jobs, so unless it was reported to me, I probably wouldn't have seen it as such.
>
> But certainly, you were aware, prior to 2 August 2010, of the risk of a tailgate or a hinge being damaged by what you described as poor operator procedure in failing to tip properly?---That's right.
>
> And - - -?---Failing to identify, in the process, that they need to use to tip the load out, yes.
>
> And a wrong decision by an operator between tipping and swinging?---Yeah."

[102] In my view, the approach to the question of foreseeability of risk advocated by the respondents focused on too narrow a question. Furthermore, the approach is coloured by looking at the question in terms of one of the alleged breaches; for example, whether the hinge pin defect was ascertainable. Additionally, the respondent's approach conflates the separate issue of foreseeability of risk of injury with those of breach of duty, causation and contributory negligence. The duty of care was required to be considered in circumstances where it was to be expected that, should there be damage to the truck, a driver would get out of the truck to inspect it and that a load, not properly loaded, might create a dangerous situation (as Mr Dalton acknowledged).

Breach of duty

The appellant's submissions

[103] The appellant's case, as stated in the written outline in this appeal, was that the respondents failed to conduct a risk assessment of the tipping operations and that, had such an assessment been undertaken, it would have revealed that it was necessary to devise and implement a procedure to instruct truck drivers as to the type of load that could be discharged under the tailgate swinging on its horizontal axis.[131] The pleaded case was that the instruction should have been that items larger than 300 mm in size

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131 [2015] QSC 264 at [9].

should not be tipped "under" the tailgate. It was argued that the correct tipping procedure should have been promulgated, maintained and enforced by the second respondent.[132]

[104] It was argued that, while the trial judge noted several aspects of the evidence relating to whether a risk assessment should have been undertaken prior to 6 August 2010 and whether or not there was a breach of a duty of care in failing to provide appropriate instruction and training to its employees, ultimately, his Honour did not determine whether there was any such breach of duty. However, determining whether there was any breach of duty in failing to provide appropriate instruction and, if so, what the appropriate instruction would be, was an essential element in determining causation.

[105] Mr Kahler's evidence was that, as a guideline, the tailgate should be swung about a vertical axis when the material size is greater than 200 to 300 mm for solid materials. Without such strong guidance, it could be expected that the opportunity for hinge damage would remain. Dr Grigg's evidence was that he would not be prepared to tip on the horizontal axis in circumstances where the dimensions of the items of concrete were greater than 200 mm.[133] The appellant submitted at trial that, given the risk of injury, the failure to have in place a system as described where drivers were specifically instructed to tip under the tailgate only if the material was solid and less than 300 mm in diameter was a breach of the respondents' duty of care to the appellant.

[106] The appellant submitted that the trial judge should have found that the failure to devise and implement a tipping procedure as described in the preceding paragraph, and to maintain and enforce such a system, was a breach of the respondents' duty of care.

The respondents' submissions

[107] The respondents submitted that, having correctly concluded that the risk of injury to the appellant was not foreseeable, it was unnecessary for the trial judge to expressly consider whether the respondents breached any duty of care to guard against such risk of injury.

[108] However, in any event, a number of unchallenged findings by the trial judge supported a conclusion that the respondents did not breach any duty of care that might be found to be owed in respect of any foreseeable risk of injury. The appellant received training when he commenced employment with the second respondent,[134] who also organised monthly toolbox meetings, at which drivers could raise any issue they had[135] and provided workshops where any issues with the trucks could be raised by drivers.[136] The drivers who drove for the second respondent were experienced operators.[137] The appellant was, accordingly, an experienced operator, and well versed in proper tipping procedures.[138] The respondents were entitled to rely on the common sense and experience of its drivers and operators.[139] The second respondent carried out a Hazard and Risk Evaluation of the activity of "loading and unloading trucks"[140] and Mr Howard, the appellant's supervisor, performed "spot checks" of drivers.

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132 Appellant's amended outline at [6].
133 AB 241.20.
134 [2015] QSC 264 at [73].
135 [2015] QSC 264 at [67].
136 [2015] QSC 264 at [67].
137 [2015] QSC 264 at [76].
138 [2015] QSC 264 at [77].
139 [2015] QSC 264 at [63], citing *Bourk v Power Serve Pty Ltd & Ors* [2008] QSC 29 at [51]-[57].
140 [2015] QSC 264 at [74].

[109] The respondents submitted that the "blanket rule" contended for by the appellant was not apt for the system of tipping required by the second respondent's operations. It was also submitted that the appellant, Mr Hinde, Mr Dalton, Mr Howard and Mr Young concurred with the proposition that it would have been impracticable to impose a "blanket rule" prescribing the method of tipping, because of the variability in the composition of loads transported by Council vehicles. It was contended that, as to this matter, the trial judge was entitled to have regard to the evidence of those witnesses who had significant experience of the practicalities of tipping operations for the second respondent, in preference to that of the experts Dr Grigg and Mr Kahler.[141]

[110] As to the evidence of Mr Kahler referred to by the appellant, the respondents contended that the primary judge's findings were supported by and consistent with the evidence. Mr Kahler's evidence was simply a guideline informed by hindsight, but which in this case did not affect or impugn the primary judge's findings on causation. For the load in question, the appellant was always aware that the tailgate should have been swung horizontally. His case was that the load was smaller than what was depicted in the photograph and that therefore the tailgate did not have to be swung. As for the evidence of Dr Grigg that was relied upon, it was a general comment informed by hindsight. It did not detract from the findings which his Honour made about there being no negligence and no causative negligence. The respondents therefore argued[142] that the appellant's contentions were irrelevant to what essentially was in issue.

[111] As for the contention that the failure to have a system in place, which was maintained and enforced, that specifically instructed operators to tip under the tailgate only if the material was less than 300 mm in diameter, it was argued that the appellant was aware of the correct tipping procedure and that for what the load was ultimately found to be[143] he should have tipped horizontally, but he did not. Further, it was clear that the appellant should not have pushed the tailgate – pushing the tailgate was in breach of what the appellant knew and he conceded was reckless. What was contended by the appellant to be breaches would not have made any difference to causation.

Discussion

[112] The appellant argued that, irrespective of the findings relied on by the respondents, it remained that his Honour, ultimately, did not determine whether there was any such breach of duty. In that regard, the appellant's submission, as stated in his written outline,[144] was that the trial judge should have found that the respondents were in breach of their duty of care in failing to devise, implement, maintain and enforce a system whereby drivers were specifically instructed to tip under the tailgate if the material in the tray was solid and less than 300 mm in diameter. That position was not retracted in oral argument.

[113] It is important to distinguish between two areas of breach contended for at trial: that concerning the appropriate instructions and procedure as to the discharging of a load under the tailgate and the other concerning the appropriate training and instructions upon there being a failure of plant or equipment. It should be noted that no submissions

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141 [2015] QSC 264 at [78].
142 Second respondent's amended outline at [23]-[24].
143 AB 535 and 580.
144 Appellant's amended outline at [23]-[24].

were made[145] to the effect that the trial judge erred in failing to find a breach of duty as to the duty to "provide proper training and instructions to truck drivers as to the taking of appropriate steps once there had been a failure of plant or equipment and, in particular, to train and instruct truck drivers that they should not approach damaged plant or equipment or to attempt to repair such damage themselves".[146] In oral submissions, senior counsel for the appellant confirmed that it was not contended that anything further needed to have been advised by the respondents "about not touching the tailgate".[147] Nor was the following finding by the trial judge challenged in the appellant's written or oral submissions:[148]

> "… because of the instructions that were in existence at the time of the accident – requiring damage to equipment to be reported and for there to be no attempt on the part of the driver to repair any such damage – as well as [the appellant's] own experience and common sense, he knew not to go near the hanging tailgate.

[114] In respect of the issue of the giving of appropriate instructions and specify an appropriate procedure as to the discharging of a load under the tailgate, the appellant contended that the trial judge failed to provide adequate reasons for rejecting the evidence of Mr Kahler as to the system of instruction that should have been implemented.[149] Mr Kahler's evidence was considered along with other evidence. However, his evidence as to that issue was that, as a guideline, the tailgate should be swung about a vertical axis when the material size is greater than 200 to 300 mm for solid materials; that was not the pleaded case.

[115] In my view, the trial judge was entitled to consider the practicality of the instruction contended for, and the fact that the appellant was engaged as an experienced driver. The trial judge rightly had regard to the evidence of the appellant, Mr Hinde, Mr Dalton, Mr Howard and Mr Young to the effect that "there could not be a 'blanket rule' regulating when to tip in a certain way".[150] The trial judge found that the system of work "substantially relied on the experience of drivers and operators such as [the appellant]"[151] and that the variation in the composition of loads drivers were required to carry may have meant that a "blanket rule" could not have been adequately developed. The question was not one as to a "blanket rule", but whether the instruction contended for by the appellant ought reasonably to have been given as part of the appropriate discharging procedure.

[116] The instruction was one that could easily have been given and, in view of the awareness on the part of the respondents of the consequences of an improper discharging procedure, one that ought reasonably to have been given. I consider that the trial judge erred in not finding that the respondents breached their duty in failing to devise and implement a procedure to instruct truck drivers as to the type of load that could be discharged under the tailgate swinging on its horizontal axis, as pleaded; that is, that drivers ought specifically have been instructed not to tip under the tailgate if the material in the tray was solid and more than 300 mm in diameter.

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145 See Appellant's amended outline at [9].
146 [2015] QSC 264 at [9].
147 TS 12.01-35.
148 [2015] QSC 264 at [92].
149 Appellant's amended outline at [10].
150 [2015] QSC 264 at [78].
151 [2015] QSC 264 at [92].

Causation

The appellant's submissions

[117] The appellant challenged the trial judge's approach that the proposed instructions would "not have added to [the appellant's] store of knowledge at the time of the accident".[152] The challenge was predicated on the implication by the trial judge that the appellant "would have, presumably, discharged the load through the tailgate despite express instruction from the employer to the contrary". The appellant submitted that his Honour should have considered "not whether the instruction simply added to [the appellant's] store of knowledge", but whether if such a system of instruction, maintenance and enforcement been in place, "[the appellant] would have intentionally disregarded the instructions" of the second respondent in the circumstances.[153]

[118] In that respect, reliance was placed on the evidence of the appellant's supervisor that he was a good, reliable worker and followed instructions. It was argued that the question of whether the appellant would have intentionally breached the second respondent's direct instructions as opposed to whether his store of knowledge would have been increased or not were different questions. The trial judge should have assessed all the relevant facts and circumstances as "to the likelihood that the performance of that instruction, which the duty required the respondents to have done, would have avoided the incident".[154]

[119] The appellant submitted that the trial judge should have concluded that, had the instruction as to the tipping procedure been given, the injury would have been avoided.

[120] Further, the breach of duty that gave rise to the damage to the tailgate caused an emergency to which the appellant responded. The trial judge's finding as to the consequence of the appellant's "push" of the tail gate did not detract from the causative effect of the breach of duty in failing to properly instruct as to the load that could be discharged under the tailgate.

The respondents' submissions

[121] The respondents submitted that the appellant failed to demonstrate that any breach of duty by the respondents caused his injury. It was argued that, for the purposes of legal causation, the sequence of events should be viewed in two stages:

- the first being that which ended when the tailgate was observed by the appellant, from the cabin of the truck, to be damaged; and
- the second commencing with the appellant's inspection of the tailgate after leaving the cabin of the truck, when the tailgate fell upon the appellant's foot after he pushed it.

[122] Given the finding that the push applied by the appellant was the disturbing force that caused the tailgate to fall, it was submitted that the "common sense" approach to causation directed attention to the appellant's actions "when fully appraised by his observations of the state of the damaged tailgate, aware of the second respondent's reporting procedures for truck damage and fully aware of the risks to which he exposed himself by attempting to push it onto the tray of the truck". Accordingly, it

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152 [2015] QSC 264 at [81].
153 Appellant's amended outline at [26].
154 Appellant's amended outline at [27].

was argued that, although procedural and training issues were relevant with respect to the tipping of loads in a manner which would or might damage the hinges, those issues concerned the first stage of events. They "*were irrelevant to the appellant's actions that were proximate to the time and causally potent to his injuries"*, namely his pushing of the tailgate.[155]

[123] It was submitted that, on the facts as found by the trial judge, the imposition of a "blanket rule" as contended by the appellant would not have altered the appellant's approach to the tipping operation to be performed on the day. The appellant's evidence was that his load contained pieces of around 300 to 400 mm in size broken up by the backhoe as it was dug out. He maintained to the time of the trial that, with the load that he contended was in his truck, it was appropriate to tip by means of the gate swinging on the horizontal axis. The appellant disagreed that the load as photographed[156] was his load on the occasion in question. The trial judge found to the contrary. The appellant accepted that if he had concrete in the back of his truck (as photographed) he would have swung his tailgate.[157] It was submitted that the cause of the appellant's injury was his failure to follow the appropriate method of tipping, which he himself believed would dictate swinging the tailgate for a load of the size that his was found to be.

[124] Given that the appellant failed to follow the tipping procedures of which he was aware, it was argued that the appellant could not now seriously contend that he would have followed the alternative tipping procedure. There was no evidence upon which the trial judge could have concluded that the appellant would have changed his tipping procedure if he had received some other instruction. The appellant was not asked in evidence whether he would have done anything different on the occasion in question if he had received the instruction for which he contended in this appeal. The respondents argued that although there was evidence generally from Mr Dalton that the appellant was a good and reliable worker who followed instruction, the inescapable conclusion was that the appellant failed to follow the process, of which he acknowledged he was aware, for a load composed of the material tipped by him.

Discussion

[125] As to the argument that the "push" of the tailgate by the appellant was the true cause of his injury and that the failure to provide proper instructions as to the unloading procedures was not an operative cause of the appellant's injury, it is to be noted, as the appellant pointed out, that the trial judge did not find that the "push" was an intervening cause breaking the chain of causation between any alleged breach of duty and the injury.

[126] The trial judge was correct in concluding that the failure to specify that loads containing solid material larger than 300 mm should not be tipped under the tailgate was not a causative factor in the accident. Even if such an instruction had been given, and accepting that the appellant would not deliberately disregard such an instruction, it remains that it was not apparent that the appellant would have acted differently with respect to the load in question.

[127] This is because the appellant's own evidence was that he observed the material being loaded. He made an assessment as to the size of the load. His assessment as to the

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155 First respondent's amended outline at [20].
156 AB 535 and 580.
157 [2015] QSC 264 at [46].

size of the load was erroneous. Contrary to his assessment that none of the pieces were greater than 300 to 400 mm in dimension, the pile contained many pieces substantially larger than 400 mm.

[128] The instruction contended for would not have prevented the serious and substantial error in the assessment of the size of the load. It would not have precluded the appellant's erroneous choice of tipping method, for a load which indisputably contained material in excess of 400 mm.

[129] The appellant believed material up to 400 mm could be discharged under the tailgate but his load contained many pieces of substantially larger size.

[130] This was not a case where the appellant alleged a breach in failing to properly implement a system of "assessing" the load. The assessment process was a visual one conducted by experienced drivers positioned in the truck and looking in the mirrors and gradually moving the truck as the dismantling of the kerbing occurred (the appellant's contemporaneous written statements were to the effect that the items being loaded were small items. The appellant affirmed his evidence in cross-examination and asserted, moreover, that he had an unimpeded view). Nor was it alleged as a breach that there ought to have been a system in place whereby only fluid substances such as sand and the like were to be tipped through the tailgate. Indeed, the pleaded breach was inconsistent with such a position and was predicated on the contrary; the pleading implied that solid material of up to 300 mm could be safely tipped through the tailgate. No amendment to the pleading was made even though the inconsistency with the pleaded case was specifically raised by the trial judge. Finally, it was never the appellant's case below or on the appeal that a proper system of assessing the load required that an assessment be conducted immediately prior to tipping.

[131] This was not a case where the issue was whether an instruction as to the tipping method would have been followed. The instruction in question could not have influenced his using the horizontal axis when he knew it was not appropriate for the load identified in the photograph but chose it in a mistaken assessment as to the size of the load.

[132] The appellant did not argue on the appeal that there was a breach of duty in relation to the instructions in the event of damage to the truck. Accordingly, there was no assertion that, if contrary to the trial judge's finding that there was no relevant deficiency in that regard, it had no causal bearing on the happening of the accident.

[133] This was not a case of inadvertence which ought to have been foreseen and catered for by an instruction. The decision to unload under the tailgate was a deliberate one based on the appellant's erroneous assessment of the load as photographed.

[134] It is not to the point that the appellant was a reliable worker who would have followed instructions. Even if the system involving instructions as to the type of load to be discharged under the gate being not more than 300 mm such instructions would not have altered matters because this was not a case where possible adherence to instructions featured. It was a case where the assessment of the load was erroneous.

[135] The conclusion by the trial judge as to causation was correct.

[136] In the circumstances, it is not necessary to consider the notice of contention.

[137] **FLANAGAN J:** I have had the advantage of reading the reasons of Philippides JA, with which I agree. I also agree with the orders proposed by her Honour.