IN THE CORONERS COURT
OF VICTORIA
AT HAMILTON

Court Reference: COR 2012 05043

FINDING INTO DEATH WITHOUT INQUEST

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

I, John Leon Lesser, Coroner having investigated the death of **Tara Jones**

without holding an inquest:
find that the identity of the deceased was **Tara Jones**
born on 18 March 2003 and aged 9 years
and the death occurred on 27 November 2012
at Glenelg Highway Carapook

from:

1 (a) Multiple injuries sustained in a motor vehicle incident (passenger).

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

1. Tara Jones was a nine year old child who tragically died on 27 November 2012 from multiple injuries she sustained in a motor vehicle incident when she was a passenger in the bunk section of her father's prime mover pulling a B-double transport truck and trailers.

2. The circumstances of the death of Miss Jones have been fully addressed in the coronial brief, which is thorough and comprehensive, and includes statements of relevant witnesses, the accident investigation and medical reports.

3. Based on the brief material, the following is a brief description of the directly relevant events:

At approximately 2.50 pm on 27 November 2012, a fatal motor vehicle collision occurred on the Glenelg Highway Muntham, approximately 47 km west of Hamilton. At the time, Miss Jones' father, Robin, an experienced professional truck driver, was driving a prime mover towing two trailers containing 630 sheep on three levels. He was accompanied by his wife, Paige, who was in the passenger seat, and his two daughters, Josie aged 6 and Tara aged 9, who were sitting in the rear sleeping cabin. Neither of the adults was wearing seat belts, and the young girls were unrestrained. Before commencing the trip to Melbourne from Naracoorte South Australia, Mr Jones replaced two

tyres on the prime mover and one tyre on one trailer. The family stopped near Casterton to buy lunch.

The collision occurred while Mr Jones was driving the truck downhill on Mount Muntham, a 204 metre elevation. The road has a single lane in each direction, is windy and has a 100 km an hour speed limit. There is a significant downhill gradient, and a right-hand curve at the bottom of the hill. Throughout the descent, there are road signs advising of both the steep descent and the right curve. Leading into the curve and throughout the curve, there are double solid white lines dividing the opposing lanes. Prior to the curve, there are several corners while the road runs downhill.

The prime mover negotiated the hill, then began its descent. As it approached the sweeping right-hand curve at the bottom of the hill, the road straightened, and the truck failed to straighten up and subsequently crashed into and through a guard railing on the north side of the road. It rolled down the left-hand side embankment. Miss Jones was ejected and suffered fatal injuries, although the exact point at which this occurred could not be established. All the other family members suffered injuries which were not life-threatening, and were taken to hospital. The prime mover became completely detached from the trailers and was extensively damaged, with the cabin and sleeper cab totally destroyed. Numerous sheep were dead and injured, with many wandering near the wreckage. Mr Jones provided a blood sample which was negative for alcohol or drugs.

A reconstruction of the collision was undertaken by a police expert, whose opinion was that the stability of the vehicle was lost during cornering because of the transfer of the load of livestock on the tyres, the high centre of gravity of the trailers, and the speed at which the vehicle was travelling. The expert explained that the tyre marks were consistent with a yaw to the left by a vehicle exceeding the rollover threshold. The expert estimated that the speed at which the prime mover was travelling was a minimum of 111 km per hour at the time when Mr Jones began to lose control of the vehicle. Other factors which may have caused the collision were investigated and subsequently excluded. There was no evidence of driver fatigue or any other obvious distractions to Mr Jones' concentration.

Mechanical experts investigated the trailers and the prime mover. They noted several issues which would have rendered them unroadworthy, including reduced braking capacity. However, it was concluded that there were no mechanical defects which would have caused the collision. The reduced braking capacity may have been a contributing factor. Mr Jones could offer no reason why the truck and trailer overturned, and denied that he had been speeding. However, he acknowledged that everyone in the truck was unrestrained.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

4. On 28 November 2012, an external examination was performed by Dr H Bouwer, a Forensic Pathologist with Victorian Institute of Forensic Medicine, who provided a report to the Coroner. His examination generally confirmed the extensive injuries suffered by Miss Jones, despite difficulties caused by the marked disruption to her body. Dr Bouwer relevantly commented:

> "2. The external examination was consistent with the reported circumstances. There was marked disruption of the body and the head was absent.
>
> 3. Post mortem CT scan showed marked destruction of the body with multiple comminuted fractures.
>
> ...

6. In the absence of a full post mortem examination, on the basis of the information available to me ... a reasonable cause of death would appear to be ... MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PASSENGER).

No toxicological testing or report were available.

FACTORS CAUSING AND CONTRIBUTING TO DEATH

5. The uncontradicted evidence is that Miss Jones died on 27 November 2012 at Glenelg Highway Carapook and that the cause of her death was multiple injuries sustained in a motor vehicle incident as a passenger.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

6. The tragic circumstances of the untimely death of Miss Jones at the age of nine years has, no doubt, had a devastating impact on her whole family. This was compounded by the fact that her father, the driver of the prime mover, was charged with and convicted of serious criminal offences arising from the incident. Miss Jones' death clearly resulted from a combination of factors. Important among these was inadvertence by an experienced truck driver, rather than anything more sinister, as was borne out by the decision of the sentencing court.

7. Patently, I must conclude that Miss Jones' death was eminently preventable. It beggars belief that neither of the adult passengers was wearing a seatbelt at the time of the collision. Worse still, the two young children were allowed to ride in the sleeping cabin unrestrained. The fact that they had accompanied their father on previous journeys in similar circumstances without incident does not reduce, explain or justify the parents' thinking. It was indeed fortuitous that no one else was killed or very seriously injured.

8. As part of this investigation, the Coroner sought advice from the Coroner's Prevention Unit (CPU) relating to previous coronial investigations involving deaths that have occurred as a result of truck collision incidents. In its report, it was noted that the *Road Safety Road Rules 2009* (Road Rules) provide the framework for sleeper cab use and the *Vehicle Standards (Australian Design Rules 42/04 - General Safety Requirements) 2005* specify the design and construction requirements for the safe operation of vehicles. Requirement 17 deals specifically with sleeper berths. Regulation 266 of the Rules deals broadly with seat belt requirements, and sub-rule (4) requires that passengers between the ages of seven and 16 must be restrained by an approved child restraint or approved seatbelt. Rule 267(7) exempts two-up drivers from wearing a seatbelt while occupying the sleeper cab for rest purposes. No other provision appears to specifically deal with the use of truck sleeper cabs.

9. In the report, the CPU identified four deaths between 2000 and 2015 involving a person occupying a sleeper cabin in a truck involved in a collision, the last being in 2006, and advised that it did not appear to be a systemic issue for trucks with sleeper cabins. The report appended two relevant findings from 2004 and 2006. The latter included a recommendation that "consideration be given to introducing legislative requirements of restraint for occupants in sleeping cabins of moving heavy vehicles". It would appear that the current Road Rules are an attempt to do this, but their success appears partial at best. In those circumstances, it does appear that it may be preferable for the law to prohibit passengers, in particular children, from sitting in the sleeper cab of trucks while the vehicle is in motion. Alternatively, the Road Rules should at a minimum be amended to

specifically require the fitting and use of approved child restraints or approved seatbelts in sleeper cabs, unless covered by the Rule 267(7) exemption.

10. While there does not appear to be a systemic problem among truck drivers, any community efforts to prevent a child's death in circumstances such as this should be fully supported. Whether such a legislative change can overcome the foolhardy individual decisions made by truck drivers such as Mr Jones to allow family members, especially children, to travel unrestrained is unclear, but it may drive a cultural change among truck drivers who, hitherto, may have been led into erroneous thinking by previous uneventful family trips before Miss Jones' death. The fact is that there is always the potential for injury or death. That this family had to suffer the tragedy that occurred to highlight the dangers to the community is regrettable on every level. It is to be hoped that any truck driver reading these findings will ensure that the tragedy is never repeated.

RECOMMENDATION

Having reviewed the evidence in this case, I am satisfied that it is appropriate to make the following recommendation:

1. That the Victorian Government consider legislative changes to the Road Rules either to prohibit passengers, in particular children, from sitting in the sleeper cab of trucks while the vehicle is in motion, or alternatively, to specifically require the fitting and use of approved child restraints or approved seatbelts in sleeper cabs, unless covered by the Rule 267(7) exemption.

FINDING

I find that that Miss Jones died on 27 November 2012 at Glenelg Highway Carapook and that the cause of her death was multiple injuries sustained in a motor vehicle incident as a passenger.

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

Ms P Jones, Miss Jones' mother

The Victorian Minister for Roads and Road Safety, the Honourable Luke Donnellan MP

Dr J Oats, Chair, Consultative Committee on Obstetric and Paediatric Mortality and Morbidity

The investigating member, Detective Acting Sergeant T Gentile.

Signature:

JOHN LESSER
CORONER
Date: 19th August 2015