IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 001022

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of ADAM JAMES ALWARD
without holding an inquest:
find that the identity of the deceased was ADAM JAMES ALWARD
born on 15 October 1985, aged 27
and that the death occurred on 9 March 2013
at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria 3004.

from:

I (a) PENETRATING NECK INJURY SUSTAINED IN A MOTORCYCLE INCIDENT.

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

1. Mr Alward was a 27-year-old man who resided in Blackburn and was employed as a garage door installer.
2. On 8 March 2013, Mr Alward and his brother, Mr Jeremy Alward, visited Strath Creek, a small town in central Victoria, for a weekend camping trip.
3. At around 7.00am the next day, the two brothers rode around the campsite on their trail motorcycles for an hour before loading them onto a trailer and driving towards Tallarook. They arrived at Horans Track, Tyaak at around 12.00pm, changed into their full protective gear and travelled up Horans Track in a northerly direction. They rode past a four-wheel drive driven by Mr Ignazio Reale along the way.
4. According to Jeremy Alward, his brother was riding in front of him as they proceeded down Jenkin Link Track. When they were negotiating a corner at approximately 5km/hr, he noticed

that his brother was suddenly thrown from his motorcycle after colliding into a fallen tree branch, which penetrated through his neck. The branch was approximately 3 inches in diameter with a jagged edged, and was elevated about one metre off the ground. Mr Alward's motorcycle travelled for a further two metres before coming to a stop.

5. Jeremy removed the branch from his brother's neck and passed him a rag to place over the wound as there was substantial bleeding. He left his brother to seek help, and managed to locate Mr Reale.

6. Jeremy used Mr Reale's phone to contact emergency services, and pleaded with him to drive to where Mr Alward was, but Mr Reale was not confident driving down the steep embankment in his four-wheel drive. Mr Alward tried to walk to the car with the help of his brother and Mr Reale, but collapsed after one kilometre, and it appears that Mr Reale then drove his car down.

7. They drove for approximately 15 minutes until they reached the road where paramedics were already waiting. Police arrived at the scene shortly thereafter. Paramedics performed cardiopulmonary resuscitation (CPR) on Mr Alward, and he was air lifted to the Alfred Hospital Emergency Department about 20 minutes later.

8. According to Dr Jack Spencer, an emergency physician at the Alfred Hospital, Mr Alward was haemodynamically unstable at the scene and during transit, and treatment provided en route included intubation, fluid resuscitation and intermittent CPR. No cardiac activity was detected on arrival and Mr Alward was noted to have fixed dilated pupils. He was pronounced deceased at 3.17pm.

9. An autopsy of Mr Alward's body was performed by Forensic Pathology Registrar Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (VIFM), who reviewed the circumstances as reported by the police to the coroner and provided a detailed written report of her findings. Dr Francis attributed Mr Alward's death to *penetrating neck injury sustained in a motorcycle incident.* Both ante and post mortem toxicological analysis of blood detected the presence of ~0.5mg/L of methylamphetamine and ~0.05mg/L of amphetamine.

10. Dr Francis advised that because of the damage to the pharyngeal wall, a significant amount of blood was swallowed and inhaled into the lungs, and that this could have resulted in hypovolaemic shock. Due to the decrease in blood volume, the heart is unable to pump an adequate supply to the tissues, resulting in hypotension (low blood pressure) and hypoxia (lack of oxygen) to the rest of the body. Young, healthy individuals are able to compensate and may maintain their blood pressure for a period of time, which explained why Mr Alward was able to

walk for one kilometre, but began to decompensate and displayed signs of hypotention and hypoxia by the time paramedics attended the scene.

11. I find that Mr Alward's death was accidental and that the cause of his death is penetrating neck injury sustained in a motorcycle incident.

COMMENTS:

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

1. The growing popularity of off-road motorcycle riding[1] and the increasing rate of injury in Victoria was highlighted in my findings into the deaths of motorcycle riders Garni Sulemani[2] and Andrew James McFarlane[3] in 2010.
2. The Parliament of Victoria Road Safety Committee released the *Inquiry into Motorcycle Safety* report in December 2012.[4] One of the terms of reference required the Committee to consider the trends in off-road riding crashes and investigate the responsibilities of road safety agencies in relation to off-road riding.
3. The inherent dangers of off-road riding were aptly expressed in the report which stated:

   "Off-road riding focuses on roads that are unsealed, undulating, sometimes dangerous and often surrounded by trees and other obstacles... Riding off-road attracts riders of all ages who are keen to test themselves against elements and the terrain and are generally aware of the high risks involved... [T]he remoteness of off-road areas can make it difficult for riders to contact emergency services and for these services to access the injured."

   Mr Alward's death occurred in just such circumstances. He went off-road riding on his trail bike and sustained serious injuries after colliding into a fallen tree branch, and rescue efforts were delayed as the accident site was difficult to access.
4. The report included extensive discussion of the lack of interdepartmental collaboration and coordination of off-road riding safety initiatives, and the road safety agencies' failure to fulfil

[1] The expression is generally understood to encompass riding anywhere other than sealed public roads, such as private land, roads and tracks in State and National forests and parks, and at official riding venues managed by riding clubs and associations. It covers a diverse range of sporting and recreational activities. It includes not only motocross and other riding disciplines at official venues, but also trail bike riding in forests and parks, and casual riding on private property such as farms.
[2] Coroners Court of Victoria case reference 243/10.
[3] Coroners Court of Victoria case reference 1626/10.
[4] Road Safety Committee, Parliament of Victoria, *Inquiry into Motorcycle Safety* (2012).

their off-road safety responsibilities. The Committee identified VicRoads' minimal involvement in regulating off-road safety, as required under the *Road Safety Act 1986* and the *Transport Integration Act 2010.*

5. According to the report, VicRoads stated that:

   "conceptually off-road riding is not on the road and hence not the responsibility of VicRoads. Having said that, we do have a role to coordinate many of the stakeholders in road safety who do have accountabilities in this area, and there is a lot we do for on-road safety that can benefit off-road road safety."

6. It appears that despite previous coronial comments and recommendations,[5] the Victorian Auditor-General's Office report[6] and the more recent Road Safety Committee report, there is still an absence of initiatives that specifically target off-road riding, and VicRoads does not appear to have acknowledged that it plays a central role in the regulation and management of both on-road and off-road safety.

7. I am aware that funding and resources are always limited, and note VicRoads' concerns about the potential detrimental effects of diverting resources away from on-road to off-road safety efforts. Nevertheless, given that off-road crashes account for a significant proportion of deaths and injuries in Victoria, there are public health and safety gains to be made by promoting off-road riding safety.

RECOMMENDATIONS:

Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the road safety agencies, particularly VicRoads, the Transport Accident Commission and the Department of Sustainability and the Environment, consider the Road Safety Committee's findings and adopt the recommendations set out in its report.[7]

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[5] See also Coroners Court of Victoria case reference 3877/09, Inquest into the death of Simon Peter Gardner in 2009 who was involved in an off-road motorcycle crash.

[6] Victorian Auditor-General's Office. *Motorcycle and Scooter Safety Program*. February 2011. The full report is available on the website: http://www.audit.vic.gov.au/reports__publications/reports_by_year/2010-11/20110209_motorcycles.aspx.

[7] See Chapter 5 of the Road Safety Committee report.

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

The family of Mr Alward

Ms Sarah Larwill, The Alfred Hospital

Mr Gary Liddle, Chief Executive Officer, VicRoads

Ms Janet Dore, Chief Executive Officer, Transport Accident Commission

Mr Adam Fennessy, Secretary, Department of Environment and Primary Industries

The Hon Terry Mulder MP, Minister For Roads

Mr David Hawker, Chair, Motorcycle Advisory Group

Mr Wayne Holdsworth, Chief Executive Officer, Motorcycling Victoria

Mr Dale Gilson, Chief Executive Officer, Motorcycling Australia

Constable Joel Page, Seymour Police Station.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **26 June 2014**