IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2010 / 4047

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 ANDREW JAMES WOODLOCK without holding an inquest:

find that the identity of the deceased was ANDREW JAMES WOODLOCK
born on 23 November 1975, aged 34
and the death occurred on 20 October 2010
at CityLink/Tullamarine Freeway, Moonee Ponds, Victoria 3039

from:

1 (a) CHEST AND ABDOMINAL INJURIES (MOTORCYCLE RIDER)

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

BACKGROUND & PERSONAL CIRCUMSTANCES

1. Mr Woodlock was a 34-year-old man who resided with Kylie Ferguson, his partner of eight years, and her two children from a previous relationship. Mr Woodlock had no significant health problems or relationship difficulties, and was like a father to Ms Ferguson's two children. He worked in the pathology service at the Royal Children's Hospital. According to his mother, Mr Woodlock started riding dirt bikes when he was 16 and was an experienced motor cycle rider who generally rode to work each day.

INCIDENT ON CITYLINK - 20 OCTOBER 2010

2. At about 5.00pm on Wednesday 20 October 2010, Mr Woodlock was riding his Honda CBR600 motor cycle outbound on City Link/Tullamarine Freeway, Moonee Ponds, which is a

multi-laned freeway. At the same time, Robert Bourke was driving a heavy rigid vehicle outbound on the same carriageway. As was a third vehicle, a prime mover/trailer combination which was displaying a 'Long Vehicle' sign at its rear, initially seen by an independent witness to be hanging off the vehicle, through a horizontal axis. [1] As Mr Bourke was travelling along CityLink, Mr Woodlock was riding in the lane immediately to his left when the bottom half of the 'Long Vehicle' sign detached from the third vehicle and moved across the roadway in front of Mr Bourke from right to left. The sign emerged into the path of Mr Woodlock, and either struck him or otherwise caused him to lose control of his motorcycle. Mr Woodlock fell from his motorcycle and Mr Bourke's truck travelled over the motorcycle and, in the view of some witnesses, over Mr Woodlock himself.

3. A number of people came to Mr Woodlock's assistance and emergency services were called. First aid was rendered by a passing transport ambulance crew, as well as by the ambulance paramedics who responded to the call to 000. Mr Woodlock could not be revived and was pronounced deceased by the ambulance paramedics. Police also attended the scene and commenced their investigation of Mr Woodlock's death.

INVESTIGATIONS

4. There was no autopsy as Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (VIFM) conducted a preliminary examination and advised that a reasonable medical cause of death was available without the need for autopsy. Dr Parsons identified multiple chest and abdominal injuries which were confirmed by postmortem CT scanning of the whole body. These included a fractured pelvis and fractured ribs predominantly on the right side, ruptured right diaphragm with displaced liver, and farcutres of the thoracic spine.

5. Postmortem toxicological analysis revealed no alcohol or other common drugs or poisons, apart from Delta -9-tetrahydrocnnabinol (commonly known as THC) at a concentration of 32ng/mL. According to the toxicologist's report, this is one of the main psychoactive ingredients of cannabis and levels in excess of 5ng/mL strongly suggest the recent use of cannabis, that is within a few hours of death. Furthermore, people who have used cannabis within a few hours are likely to still be adversely affected in terms of the impairment of skills used in driving motor vehicles or riding motor cycles, such as reduced cognitive and psychomotor functions. The level of impairment

[1] The witness stated that he "…saw that the yellow 'LONG VEHICLE' sign on the back was cracked in half, horizontally. Then it dropped and skidded along the road. I swerved a little and it's come past my right front wheel and kept going. I've looked in my mirror to watch it keep going. I noticed the vehicles behind me were moving around a bit as well, trying to avoid it…"

can vary greatly from one person to the next, and depends at least in part on the degree of habituation to the drug.

6. This finding is based in large part on the investigation and comprehensive brief of evidence compiled by one of the attending police officers, Leading Senior Constable Mathew Brooks from the Fawkner Highway Patrol. Driving conditions were very good at the time of the collision with no apparent issues arising from any aspect of road infrastructure and prevailing weather. Traffic was heavy given the time of day but still flowing. Witnesses to the collision did not report that either Mr Woodlock or Mr Bourke had been driving in an erratic or unusual manner, or at speed, which was consistent with CityLink CCTV footage viewed by LSC Brooks.

7. By accessing CityLink tolling records, LSC Brooks identified the prime mover and trailer combination from which the sign had become detached. He ascertained that the trailer was operated by XL Express with premises at Barrie Road, Tullamarine

8. Perusal of the records of XL Express indicated that the Pre-trip Safety Checklist completed by David Roscoe who was the relevant driver on the morning of 20 October 2010, bore no notations as to the condition of the sign. Mr Roscoe was described by his supervisor Shaun O'Rourke as being very particular in checking for even the slightest damage on a vehicle/trailer. Accepting that evidence, I find it likely that the pending failure of the sign was not evident at the time.[2]

ADDITIONAL INVESTIGATION AS TO SIGNAGE

9. At my request, LSC Brooks attended the premises of XL Express on 28 February 2012, took photographs and made measurements of the same prime mover and trailer combination in a simulation of conditions on the 20 October 2011, and spoke to the manager Michael Palibrk who cooperated with the investigation. LSC Brooks provided an additional statement encapsulating those discussions and observations on the day. Based on that statement, I am satisfied that while the 'Long Vehicle' sign itself apparently complied with the Road Safety (Vehicle) Regulations 2009, it was affixed to the trailer so that its lower edge was only about 380mm from the road surface, well under the minimum required clearance of 500mm.[3]

10. An independent expert report was requested from Metallurgist and Engineer Barry Gartner, principal of AMAT Engineering Pty Ltd. Mr Gartner was provided with a copy of all the available evidence including photographs, the top half of the 'Long Vehicle' sign that was removed from the

[2] This is entirely consistent with the expert metallurgical evidence – see paragraph 7 below.

[3] Schedule 2 of the Road Safety Regulations (Vehicles) Regulations 2009 requires, inter alia, that a warning sign must be fitted so that no part of the sign is over 1.8m above ground level and under 500mm above ground level.

trailer for this purpose, and the bottom half of the sign that had been collected by police at the scene.

11. Based on Mr Gartner's comprehensive and detailed report, I am satisfied that the two parts were from the same sign; that there was no distinct evidence of progressive fatigue type fracture in either the sign, the three metal hinges or rivets such as might suggest sub-standard metal; but rather this was a situation of a severe impact or overload on the lower half of the sign causing it to "fail". Mr Gartner explored a number of possibilities but expressed the opinion that the more likely scenario was that:

> *"The trailer has been backed into something low down that had impacted the lower half of the sign resulting in fracture of at lest the centre hinge, partial or complete fracture of the right hand hinge, and partial fracture of the left hand hinge. The remainder of the left hand hinge has subsequently separated by tearing during travel, allowing the lower half of the sign to fall away."*

ROUND-TABLE CONFERENCE – 11 MAY 2012

12. Having identified in relation to the investigation of Mr Woodlock's death, the potential for coronial comments and/or recommendations aimed at improving the safety of road users, I asked the Coroners Prevention Unit[4] to convene a round-table conference of relevant stake holders to assist me in arriving at practical and sensible comments and/or recommendations.[5]

13. A consensus view expressed by participants was that long vehicle warning signage is largely an operational matter, rather than something which can be regulated at the point of registration. While signs can be affixed at the time of manufacture, they are often fitted later and are removed (and therefore required to be removable) in accordance with day to day operational requirements. Industry practice is for operators to purchase and register a trailer before making a decision as to its use in B-double configuration or otherwise. Moreover, a given trailer may not always be used in B-double configuration, and may be used as a single trailer.

[4] The CPU was established in 2008 to assist coroners in the fulfilment of their prevention role by assisting with coronial investigations, the formulation of prevention focused comments and recommendations, and the monitoring of responses to comments and recommendations once published.

[5] Participants were Mr Ian Wright, Ian Wright & Associates, Secretary Over-Dimensionals Group; Mr Philip Lovell, Executive Director Victorian Transport Association; Mr Barry Hendry, Manager Vehicle Standards, VicRoads; LSC Matthew Brooks, LSC Tania Cristiano from the Police Coronial Support Unit, Ms Lisa Brodie, Coroners Prevention Unit.

14. The positioning and configuration of long vehicle (and other) signage can vary greatly depending on the type of trailer, for example whether it was a pan-technic, a low loader with a ramp, or depending on rear door arrangements. VicRoads advised that their Heavy Vehicle Transport Safety Service Officers would check that signage was displayed as required during any walk-around inspection of the vehicle, but may not routinely check measure the placement of signs, relying on their own professional judgement.

15. There was also consensus amongst participants that more prescriptive regulations with respect to the method of securing signage was not indicated. Rather, dissemination of this finding to key bodies within the transport industry and regulatory authorities, would be a better way of raising awareness of the risk posed to all road users by poorly affixed signage. To this end, there was support for the inclusion of photographs in this finding, for ease of comprehension of the safety issue identified.

PHOTOGRAPHS – ATTACHMENTS A, B & C

16. Attachment A is a photograph of the trailer with the top half of the 'Long Vehicle' sign still affixed, as sighted by LSC Brooks on 28 February 2012. This photograph was taken with the trailer under load and affords an estimation of the sign's sub-optimal clearance from the road surface.

Attachment B is a photograph of the two sections of the 'Long Vehicle' sign appearing at page 8 of 24 of Mr Gartner's report dated 9 August 2011.

Attachment C shows a 'Long Vehicle' sign with a piano hinge running across the full length of the sign – first in the open and then in the closed position, secured with a wing nut.

CONCLUSION

17. I find that Mr Woodlock died from chest and abdominal injuries sustained as a motorcycle rider when he was either struck by or attempted to avoid part of a Long Vehicle warning sign which became detached from an XL Express trailer. Although there is evidence to support a finding that his ability to ride safely would have been impaired by the recent use of cannabis, I find that the exigency of the situation caused by the sign's failure was such that it would have imperilled any road user motorcycle rider, even a highly experienced rider with full control of their faculties.

COMMENTS

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

1. The circumstances in which Mr Woodlock sustained fatal injuries highlight some basic yet important steps to ensure that long vehicle (and potentially other) warning signs do not pose a risk to road users –

1.1 Signs must be positioned on the vehicle in compliance with Regulation 62 of Schedule 2 of the Road Safety (Vehicles) Regulations 2009, that is so that no part of the sign is less than 500mm above the ground or more than 1800mm from the ground.

1.2 Signs must be safely secured to the vehicle and be sufficiently protected to reduce exposure to stress or damage.

1.3 Regular inspection and maintenance of the condition of any signage should be undertaken by operators and/or drivers, for example during pre-drive checklists to identify any damage sustained during use.

2. Regrettably, the sign which failed so spectacularly on 20 October 2010 leading to Mr Woodlock's death, had not been affixed to the trailer in compliance with the regulations, and sat about 380mm from the ground, exposing it to the potential for impact damage.

3. I wish to formally thank and acknowledge the assistance of the stake holder participants in the round-table conference – Mr Ian Wright, Mr Philip Lovell and Mr Barry Hendry.

RECOMMENDATIONS

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

1. I recommend that VicRoads and the Victorian Transport Association, through their respective industry networks, communicate to the broader transport industry, about the need to ensure that 'Long Vehicle' (and other) warning signs are correctly positioned and securely attached to heavy vehicles, in the interests of the safety of all road users.

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

This finding in its entirety and Attachments A, B and C.

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

The family of Mr Woodlock

Leading Senior Constable Mathew Brooks (#29608) c/o O.I.C. Fawkner Highway Patrol

Mr Philip Lovell, Executive Director, Victorian Transport Association

Mr Gary Liddle, Chief Executive, VicRoads

Mr Rob Perkins, Executive Director, Australian Road Transport Suppliers Association Inc

Mr Stuart St Clair, Chief Executive, Australian Trucking Association

Mr Wayne Mader, State Secretary, Victorian/Tasmanian Branch, Transport Workers Union

Mr Robert Hogan, General Manager Vehicle Safety Standards, Commonwealth Department of Infrastructure and Transport

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date**:** 9 August 2013