FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 243/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: SULEMANI
First name: GARNI
Address: 5 Cremin Close, Mill Park, Victoria 3082

without holding an inquest:

find that the identity of the deceased was GARNI SULEMANI born on the 11th August 1988,

and that death occurred on the 15th January, 2010

at Broadmeadows Motocross Park, 434-472 Mahoneys Road, Campbellfield, Victoria 3061

from: 1(a) LEFT HEMOTHORAX
1(b) MOTOR BIKE ACCIDENT (DIRT RACING)

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Garni Sulemani was a 21 year old plumber and keen motocross rider who was at Broadmeadows Motocross Park with his brother, Bislim Sulemani, and four other friends on the evening of 15 January 2010. At about 8.30pm, Mr Sulemani attempted to clear two jump mounds in one manoeuvre when, for some unknown reason, he separated from his bike mid-air and fell onto the crest of the second jump. Mr Sulemani was unconscious and died at the scene despite the attendance of ambulance officers within ten minutes or so of the incident.

2. Police also arrived and commenced their investigation of Mr Sulemani's death.[1] They ascertained that Mr Sulemani was an experienced and competent motocross rider who was wearing all appropriate protective clothing at the time, including a helmet. Although it was dusk at the time, a video taken by his brother verified that lighting conditions were adequate. None of the other riders were riding near enough to be involved in the incident. Subsequent mechanical inspection identified no mechanical fault or problem with the bike which could have caused or contributed to the incident.

3. Nor did police identify any problem with the track which was a prepared, off-road, motocross track of gravel and dirt construction which appeared well maintained and was dry at the time. Police noted that the incident took place outside the normal operating hours of Broadmeadows Motocross Park - Wednesdays from 2.00pm until "dusk" at the operator's discretion and from 10.00am to 5.00pm on Saturdays, Sundays and public holidays.

4. Mr Alan Benney, the owner, advised police that Mr Sulemani and his friend John Hassal were well known to him and regularly rode as "sweep" riders, that is much like life guards at the beach, keeping an eye on track conditions, monitoring the behaviour of other track users and reporting any maintenance issues or rider incidents back to management. Mr Benney allowed Mr Sulemani and his friends access to the track after hours provided they told him in advance as they had done on this occasion.

5. Police were unable to ascertain the reason why Mr Sulemani and his bike parted mid-air and concluded that he had died as a result of a tragic accident, with no evidence of any contribution from any other person, any mechanical fault or problem with the bike or any problems with the track.

6. Noting the family's objection to autopsy on religious grounds, and in light of the advice from Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM) that a reasonable medical cause of death was available, I did not order an autopsy. However, Dr Bedford did conduct an external examination in the mortuary, reviewing the circumstances as reported by the police and considering postmortem CT scanning of the whole body which showed a double fractured mandible, no intracerebral haemorrhage and a massive left hemothorax. He advised that it would be reasonable to attribute Mr Sulemani's death to *left hemothorax secondary to motor bike accident (dirt bike).*

7. Toxicological analysis of postmortem samples from Mr Sulemani was also undertaken at VIFM and detected no alcohol or other commonly encountered drugs or poisons.

8. I find that Mr Sulemani died from injuries sustained in a motor bike accident, that is a motocross accident, involving no other riders and no apparent problems with the track on which he was riding. This death of a competent, experienced and suitably attired motocross rider on a familiar track in good riding conditions speaks to the inherent dangers of the sport.

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1 One of attending police officers was Senior Constable Rohan Clapham from Fawkner Highway Patrol who compiled the investigative/coronial brief on which this finding is largely based.

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

1 Given the circumstances in which Mr Sulemani died, and in the interests of the prevention of deaths in similar circumstances in the future, I requested the Coroners Prevention Unit (CPU)[2] to report on the number of previous motocross rider fatalities in Victoria, including in particular any previous fatalities at the same venue.

2 According to the CPU report, and by way of context, the popularity of off-road motorcycle riding[3] has steadily increased in recent years, by any measure. For example -

- sales of off-road motorcycles nationally increased by 50% between 2004 and 2008.
- in 2009, there were 42,848 off-road bikes sold nationally, compared to 42,372 road bikes.
- the number of recreation-registered motorcycles in Victoria doubled between 2005 and 2010 from 9,220 to 20,657, and
- a 2010 survey found that one in five licensed motorcycle riders in Victoria also rode off-road/trail bikes.

3 During an 11 year period between 2000 and 2010 inclusive, there were 13 fatalities identified as having occurred at official riding venues in Victoria, including 6 motocross riders. The report is summarised in the following salient facts-

- Nine of the 13 deaths occurred during an official race, including three motocross races.
- Deaths occurred across 7 different venues in Victoria, including an earlier death at the Broadmeadows Motocross Park in 2004.[4]
- All the deaths were of male riders aged, while all the motorcross riders were aged between 12 and 41.
- All motocross riders were described as experienced and competent, and all were wearing appropriate riding attire and protective gear when they sustained fatal injuries.
- Three of the six motocross riders died when they parted from their bike and impacted the ground during of after a jumping manoeuvre.

4 CPU noted that the expression "off-road motorcycling" 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. For comparison purposes, CPU identified all off-road two-wheeled motorcycling

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2 The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroners Court of Victoria. The CPU assists coroners in formulating prevention comments and recommendations, and monitors and evaluates their effectiveness once published.

3 The expression is generally understood to encompass riding anywhere other than on 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.

4 Consistent with information from the Manager of the venue provided to the investigating member and incorporated in the coronial brief.

fatalities in Victoria, for the same 11 year period, that is between 2000 and 2010 inclusive. There were 68 fatalities within this broader group, with deaths at official riding venues accounting for about 20% or 13 out of 68 deaths, second only to trail bike riding on public land.

5 The Victorian Auditor-General's Office (VAGO) released a report in February 2011 canvassing the extent of off-road motorcycling injuries in Victoria.[5] According to that report, the Department of Health recorded a total of 3,995 emergency department presentations and hospital admissions for motorcycling injuries sustained in "off-road and unspecified" locations. Importantly, the VAGO report concluded that insufficient attention had been paid to off-road motorcycling safety by road safety agencies in Victoria to date and identified the Victorian Motorcycling Advisory Council (VMAC) as having -

> *"...proved a valuable forum for bringing together the agencies responsible for motorcycle and scooter safety, and delegates representing industry and riders. It has provided a valuable testing ground for proposals and is a catalyst for agencies, and industry and community representatives to work together to address safety issues."*[6]

6 In March 2011, a coronial finding was delivered by Victorian Coroner John Olle in relation to the death of Simon Gardner.[7] While there are significant differences between that coronial investigation and the present one, I note the comments and recommendations made by Coroner Olle, in particular the recommendation pertaining to the establishment of a sub-committee of the VMAC to examine off-road motorcycling which will be echoed below.

7 A significant injury and fatality rate is associated with off-road motorcycling in Victoria. The diverse nature of off-road riding means that different agencies have an important role to play according to the particular setting in which the injury or fatality occurred. Rider characteristics and motivations, injury risk factors and appropriate control measures will also vary. However, potential strategies to minimise risk may well be transferable across the range of off-road riding settings. This invites a broad and collaborative approach to this important public safety issue.

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 establish a sub-committee of the Victorian Motorcycling Advisory Council, whose prime responsibility is to examine off-road motorcycling incidents in order to develop evidence-based strategies to reduce the number of injuries and fatalities.

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5 Victorian Auditor-General's Office. *Motorcycle and Scooter Safety Programs.* February 2011, The full report is available on the website: http://www.audit.vic.gov.au/

6 Page 12 of the VAGO report.

7 Court reference 3877/2009. The full text of the finding can be found on the Coroners Court of Victoria website: http://www.coronerscourt.vic.gov.au/

2 Reflecting the diversity of off-road motorcycling or riding, I recommend that the sub-committee examine incidents across the broad spectrum of off-road riding disciplines and settings.

3 Without wishing to be prescriptive about the sub-committee's composition, I would expect that Motorcycling Victoria and WorkSafe Victoria would have a valuable contribution to make in respect of motocross riding at official venues.

DISTRIBUTION OF FINDING

Apart from the Sulemani family and VicRoads, I direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to the following for their information and any action deemed appropriate:

- Senior Constable Rohan, Fawkner Highway Patrol, Victoria Police
- Gary Liddle, Chief Executive - VicRoads
- The Hon. Terry Mulder- Minister for Roads
- Jim Betts, Secretary - Department of Transport
- Greg Tweedly, Chief Executive - WorkSafe Victoria
- Andrew Weiss, Chief Executive Officer - Motorcycling Victoria
- Simon Overland, Chief Commissioner - Victoria Police
- Janet Dore, Chief Executive Officer -Transport Accident Commission

Signature:

Coroners Court of Victoria

PARESA ANTONIADIS SPANOS
CORONER
Date: 18th May, 2011