

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 0117

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, AUDREY JAMIESON, Coroner having investigated the death of HUGH NEVILLE MONROE

without holding an inquest:

find that the identity of the deceased was HUGH NEVILLE MONROE

born 27 November 1947

and the death occurred on 10 January 2010

at Spring Creek Road, Tatong 3673

from:

1 (a) MULTIPLE INJURIES POST MOTOR VEHICLE ACCIDENT (FIRE TRUCK)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mr Hugh Neville Monroe was 62 years of age at the time of his death. He lived with his wife, Mrs Kathryn Monroe in Tolmie. He acted as a 3rd Lieutenant in the Country Fire Authority (CFA) at the Tolmie Fire Brigade. His medical history included obstructive sleep apnoea, post traumatic stress disorder (PTSD), mild hypercholesterolaemia, diverticular disease, osteopenia, right carpal tunnel syndrome (2006), neck pain relating to a motor vehicle accident, Type 2 Diabetes Mellitus, multinodular goitre and back pain.
2. At approximately 6.10am on Sunday, 10 January 2010, Mr Monroe was driving a fully loaded CFA 1992 Isuzu tanker north along Spring Creek Road in Tatong with four other volunteer fire-fighters from the Tolmie Fire Brigade. The tanker was on its way to a mopping up and

monitoring job at Lake Mokoan near Benella. The CFA members were not responding to an emergency call and were not travelling with emergency flashing lights or siren activated.

3. Of the four passengers, three were seated in an open, rear facing enclosure known as the Roll Over Protection Structure (ROPS), and one was seated in the front passenger seat within the enclosed cabin.
4. The tanker was negotiating a right hand 80 degree curve when Mr Monroe appears to have lost control of the vehicle, oversteering to the right, impacting a tree on the rear near side tray deck close to the rear tyre. As a result of the impact, the tanker rotated anticlockwise and slid sideways, colliding with a second tree. Mr Monroe was immediately unresponsive. He was unable to be revived and died at the scene.
5. The front seat passenger sustained bilateral rib fractures, fractures to his second and third thoracic vertebrae, an abdominal wall haematoma, a right haemopneumothorax and soft tissue injuries. The other three passengers also suffered varying injuries, some requiring hospitalisation and rehabilitation.
6. The CFA radio was damaged in the collision and there was no mobile telephone coverage. Two of the surviving CFA volunteers had to walk 1.5km to the nearest house to raise the alarm. Emergency Services were contacted. The homeowner from 1.5km away drove to the collision site and remained there until Emergency Services arrived. In the interim, a local General Practitioner was driving along Spring Creek Road and stopped and looked after the two remaining CFA members.

INVESTIGATIONS

Forensic Pathology

7. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a post mortem examination on the body of Mr Monroe, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury.
8. Toxicological analysis of blood retrieved post mortem identified a very low level of alcohol, which Dr Bedford stated is likely due to some decomposition and noted a negative alcohol reading in the vitreous humour sample. A small amount of sertraline, an antidepressant

medication, was also noted in toxicological testing. Dr Bedford ascribed the cause of Mr Monroe's death to multiple injuries post motor vehicle accident (fire truck).

Police investigation

9. The circumstances of Mr Monroe's death have been the subject of investigation by Victoria Police on my behalf. Coroner's Investigator Detective Leading Senior Constable (DLSC) Ben Howie of the Major Collisions Investigation Unit (MCIU) concentrated the investigation on drugs, alcohol or a medical condition, possible driver fatigue, vehicle, environmental and road conditions, driver training and education; the no spin differential; and possible driver error (excessive speed).
10. Statements were obtained from the passengers, the homeowner and General Practitioner who assisted, MCIU LSC Glen Urquhart, CFA Operations Officer, State co-ordinator – Driving and Vehicle Operations (Fiskville) Mr Glenn Jennings and Mechanical Investigator with the Victoria Police Mechanical Investigation Unit Acting Senior Sergeant (ASS) Leigh Booth.

Mr Monroe's experience and training

11. Mr Munro joined the Australian Army in 1968 and was a full time soldier with the Royal Australian Engineers. He was sent to Vietnam in 1968 where he served for approximately 12 months. He returned to Australia for a short time and requested another overseas posting. He was sent back to Vietnam in 1969 for approximately four months, during which time he sustained a back injury and returned to Australia. Mr Monroe married his first wife shortly after his return. The marriage lasted 12 years and bore two children. Mr Monroe met Mrs Kathryn Monroe in 1981 and the two married in 1983, following his divorce. He remained in the Army for approximately 20 years and was posted to different Engineer postings in various Australian States. When he came to Melbourne, he was posted to the 7th Engineer Regiment in Ringwood as Transport Supervisor. Whilst at Ringwood, part of his role was to train Army Reservists in driving military vehicles.
12. In April 1984, Mr Monroe was sent to Holsworthy Barracks in Sydney and then to Puckapunyal Army Barracks as a Transport Training Supervisor. He was transferred again before resigning in March 1988. He then joined the Army Reserve as a Sergeant on a part time basis. He remained in this position for seven years.

13. An account of Mr Monroe's service with the Australian Army was obtained from the Chief Driving Instructor for Defence (CDI). As it was not possible to locate a training package for a course conducted so long ago, it was not possible to positively identify the vehicle on which Mr Monroe was initially trained. On the available material, the CDI was able to ascertain Mr Munro held licences for the following vehicles:
- a. staff car (obtained 1970);
 - b. Land Rover (obtained 1970);
 - c. 1.5 tonne Dodge/International (obtained 1970);
 - d. International Mk 3, 4 and 5 (obtained 1970);
 - e. International F1 Tipper (obtained 1970);
 - f. Supervisor Transport Course/Testing Officer (completed 1971);
 - g. semi trailer predominantly operated on sealed and second class unsealed roadways (obtained 1977); and
 - h. Mack conversion training (completed 1983).
14. The CDI advised the majority of Mr Monroe's driving training was conducted at the Royal Australian Army Service Corps training centre at Puckapunyal. The CDI advised there would have been a theoretical and practical component of his training, followed by numerous periods of practical skill application and assessment.
15. The CDI advised that as Mr Monroe was a member of the Royal Australian Engineers, his driving tasks would have included but not been limited to:
- a. carriage of troops;
 - b. cartage of general freight/equipment;
 - c. movement of and recovery of plant equipment;
 - d. haul road operations;
 - e. road construction tasks; and

f. bridging laying operations.

16. The CDI advised the majority of these tasks would have been conducted on second class roads/cross country environments.
17. Mr Monroe then joined the Victoria Police as a Protective Services Officer and remained in that role for approximately 10 years. He left at 50 years of age and retired from full time work. After retiring he applied for and was granted a Total Permanent Incapacity for work, and received a Gold Care from Veteran Affairs which covered all health matters.
18. Mr and Mrs Monroe moved to Tolmie in 1998. Mr Monroe joined the Tolmie CFA as a volunteer shortly after moving, a position he held until his passing. He was also involved in a number of community services.
19. Mr Monroe was an experienced CFA member. He was considered by his peers to be a safe and reliable driver. He had no formal driving training recorded with the CFA,¹ but there appeared to be an understanding regarding the training he received with the Australian Army to instructor level during his service. He was used by the CFA to conduct driver assessments on brigade members. He was a regular driver of the tankers and was familiar with their operation.
20. Mr Monroe was the holder of a full and current Victorian driver licence endorsed to drive heavy vehicles. He obtained this endorsement by completing an accredited heavy vehicle test according to VicRoads requirements. He was licensed to drive the CFA tanker.

Mr Monroe's medical history

21. A search of the Medicare database indicated no claims were made by or on behalf of Mr Monroe and no pharmaceutical benefits had been recorded for Mr Monroe for the period January 2009 to January 2010. It was later discovered that Mr Monroe's medical expenses were funded by Veterans Affairs.
22. A statement was obtained from General Practitioner (GP) Dr Laura Carter. Mr Monroe had been a patient of Dr Carter's since 2006. Dr Carter explained Mr Monroe's symptoms of PTSD began in approximately 1998 and was considered to be associated with his Army service. He

¹ I note this was also the case in the Inquest into the death of Trevor James Day, COR 2006 0303.

was treated at the Austin Hospital Veterans' Psychiatry Unit, and had some inpatient admissions.

23. A Form 4 Request for Statement pursuant to section 42 of the *Coroners Act 2008* dated 1 May 2013 was issued to Ms Lynette Russell of Austin Health. Ms Russell was asked to provide a statement about Mr Monroe's engagement with Austin Health, or an overview of his condition and treatment.
24. Austin Health Psychiatrist Dr John Wardell provided a statement in response to the Form 4 request. Dr Wardell had treated Mr Monroe from 2003 until September 2009, when Dr Wardell ceased work for the Veterans' Outpatient Clinic. Mr Monroe's involvement with Austin Health began in 1996, when he self-referred and was diagnosed with chronic, war-related PTSD. He was prescribed antidepressant sertraline in approximately 2004. Mr Monroe did not report PTSD symptoms in 2009. He was last seen at the Veterans Outpatient Clinic on 28 October 2009. At the time, he was described as stable, with no risk issues identified. A review was planned for the middle of January 2010.
25. A statement was obtained from Mrs Kathryn Monroe, who described her husband's mental health state as being excellent prior to the collision. He was active in the community, enjoyed a recent Christmas celebration and had a new grandchild.

The fire tanker

26. The vehicle subject of the collision was a 1992 Isuzu FSS 500, 2.4D CFA tanker. The vehicle had a gross vehicle mass of 10,000kg and was last weighed on 23 June 2009 as part of a routine CFA inspection. It weighed in at 8,600kg. The vehicle had been modified to meet CFA specifications. The vehicle's tare mass was 8,320kg. Providing for an allowance of 600kg for crew, the truck would weigh approximately 9,200kg and had a capacity to carry 2,000L of water. The water tank was reported as full at the time of the collision. According to one of the CFA volunteer passengers, there is a policy that tankers must always be full when driving.

27. The CFA tanker was fitted with a No Spin Differential (NSD)² on the rear differential only. DLSC Howie explained a disadvantage of NSD as being if a vehicle is negotiating a corner, power to each rear wheel can change.³ If this change occurs, it may cause the vehicle to understeer and may cause the vehicle to take a larger radius than normal during the turn. Standard teaching is that when negotiating a corner, drivers approach at a safe speed, in the correct gear and slightly power through the corner. Mr Jennings stated it is not possible to determine whether the NSD transferred drive from one wheel to another during the cornering. DLSC Howie opined if Mr Monroe approached the curve at a speed above what is safe for the corner, he may have applied steering or brake inputs which caused the NSD to transfer drive from one side to the other, contributing to the loss of control.
28. The vehicle was examined by ASS Booth and was classed as being in a roadworthy condition prior to the collision. There were no faults identified that would have caused or contributed to the collision.
29. On 17 February 2010, DLSC Howie attended the Vehicle Impoundment Support Unit with VicRoads Transport Safety Officer Mr Adrian Redfern. Mr Redfern used portable scales to weigh the CFA tanker. The total weight of the vehicle was 6.8 tonnes, not including a quantity of water that leaked out of the tank after the collision,⁴ or a quantity of equipment that was removed during the vehicle recovery.⁵ The total tanker weight was 7.28 tonnes.
30. The vehicle was also inspected by CFA Manager, Fleet Reliability Mr Tim Smith, who has specific knowledge of these vehicles. Mr Smith also examined the maintenance records of the vehicles and concluded that the vehicle had been properly maintained. Mr Smith also did not identify any mechanical faults and considered the damage to be consistent with the

² Mr Jennings' report explained all CFA tankers have NSD fitted to improve and/or enhance traction in off road situations. The advantage is that drive can be transferred from a spinning wheel to the opposite wheel which can therefore provide or improve traction. It allows vehicles, particularly two wheel drive vehicles to negotiate terrain normally traversed by four wheel drive vehicles. They are automatic in operation and the driver has limited control over it. If power is not supplied throughout the cornering process, if one wheel, being the outside wheel rotates more than 3% greater than the inside wheel, drive may be transferred to the inside wheel. This causes understeer and may, depending upon the circumstances cause the vehicle to take a larger radius than normal. Mr Jennings said it is not possible to determine whether this occurred during the tanker's cornering process.

³ Jennings explained the NSD offers more advantages than disadvantages to the drivers of the CFA tankers and recommends they continue to be installed. Jennings opined the operation of these differential will be better addressed as the CFA Driver Education Strategy is implemented.

⁴ As the water tank was full at the time of the collision, DLSC Howie determined that water movement would not have been a contributing factor.

⁵ The equipment was weighed at 480kg.

circumstances of the collision. Mr Smith provided a report: *Motor Vehicle Collision Investigation Final Report*.

31. The vehicle was not fitted with Electronic Stability Control (ESC)⁶ as it was not an option or standard fitment to these vehicles at the time of manufacture.
32. The tanker was fitted with a 'Spider' brand GPS system which transmits three dimensional data (speed, direction and altitude) to a secured server every two minutes. The last recorded speed on this device was 70kph. The timing relative to the collision is not known.

Motor Vehicle Collision Investigation Final Report (CFA) (CFA Report)

33. The CFA Report notes Tolmie Captain John Valcich states he understood Mr Monroe had received driver education during his service to the Australian Army, and later became an Army driving instructor. Mr Monroe was a regular driver within the brigade and had driven the Tolmie Tanker on its monthly test run several weeks prior to the collision. Captain Valcich used Mr Monroe to undertake driving assessments on brigade members to determine who should be endorsed to drive the tanker as per the Chief Officer Standard Operating Procedures (SOPs).
34. The CFA Report states the critical curve speed does not directly apply in this case as the vehicle rolled over as a result of hitting the first tree. However, faint yaw marks from the inside wheels indicate the tanker was close to its critical curve speed. The CFA Report found based on the calculations and tests conducted at the scene that the tanker was travelling at a speed that was approximately 13 to 21kph in excess of being suitable to safely negotiate the bend. The CFA Report also found the line taken by the tanker in conjunction with the calculated speed led to the tanker yawing into the loose shoulder of the road and into the first tree.
35. The CFA report found it is not possible to determine whether the 70kph final speed reading transmitted from the Spider GPS was immediately prior to impact or one minute and 59 seconds before impact.

⁶ ESC helps drivers to avoid crashed by reducing the danger of skidding, or losing control as a result of oversteering. ESC becomes active when a driver loses control of their car. It uses computer controlled technology to apply individual brakes and help bring the car safely, back on track, without the danger of fish-tailing (Source: How Safe if Your Car – TAC website, cited in the CFA report (see below). DLSC Howie opined that in the same circumstances, the CFA tanker fitted with ESC would *not* have been able to safely negotiate the curve and maintain control.

36. The CFA Report refers to the Victorian Statement Government Transport Policy which requires vehicles to have ESC if available. This policy, however similarly does not apply to heavy vehicles. The investigating officer opined that as this technology becomes more readily available and affordable for heavy vehicles, the CFA should include this feature as standard for CFA fire fighting vehicles.
37. The CFA Report lists a variety of reference material relating to driving CFA vehicles, including various manuals, SOPs, and training videos. The CFA has been actively involved in driver education for many years. The Training College and all CFA Regions have been conducting driving courses since the early 1970s and continues to do so today. These driving courses were popular and well attended for many years, however in recent years, there has been a decrease in the number of personnel applying for these courses. This trend has been attributed to costs, and the time involved in attendance. In 2008, the CFA developed and distributed a discussion paper in relation to the future of driver education. The Volunteer Fire Brigades Victoria was due to provide a written report outlining their preferences and concerns with the discussion document in May 2010.
38. Within the relevant Region, Region 23, current driver education for on-road driving consists of members receiving theory presentations relating to CFA SOPs and the *Road Safety (Road Rules) Regulations 2009*. These presentations relate to emergency vehicle response and general road rules applicable to driving CFA vehicles. All members attending are issued with the CFA booklet "Requirements for Driving CFA Vehicles". At January 2010, the CFA planned on developing a driver education strategy that year as a result of the discussion paper that was at the time circulating for consultation and feedback.
39. The CFA Report's key findings include:
 - a. Mr Monroe was driving with the knowledge of the Brigade Captain and endorsed in accordance with requirements under the Chief Officers Standard Operating Procedure (SOP) 12.3, procedure 3.3;
 - b. the speed and line taken by the tanker when attempting to travel around a right hand bend was not appropriate in the circumstances. The line and speed therefore contributed to the collision;
 - c. the driver was wearing a seatbelt; and

- d. region 23 has a driving education program currently in place to meet its ongoing commitment to on road driving courses.

40. Recommendations include:

- a. the CFA's Appliance Design & Evaluation Steering Committee relevantly considers future vehicle specifications include ESC when available and within budget,
- b. the Director of Human Resources considers the following:
 - i. as part of the strategy for future driver education, it is imperative that all drivers' qualifications are recorded on TRAIN; and
 - ii. endorsements for drivers should be recorded on the Incident Management System (IMS).

Road condition

- 41. Spring Creek Road, Tatong, is an undulating, undivided dirt road approximately 4-5m wide. The speed limit is a default 100kph. The road surface is loose gravel and according to motorists that frequently drive on it, the surface grip and condition is variable depending on environmental conditions or how many log trucks drive on it. There is a steep downhill gradient prior to the right curve. After exiting the curve, there is an uphill gradient.
- 42. DLSC Howie explained the critical curve speed⁷ for this section of road for the CFA tanker is 80kph. The critical curve speed of 80kph means that the vehicle negotiating the curve in excess of 80kph has an increased risk of yaw, which continues to increase as the excess speed increases.
- 43. The road was in good condition with no pot holes, corrugations or obvious hazards. DLSC Howie concluded the road condition did not cause or contribute to the collision. A CFA volunteer passenger stated that approximately four days prior to the collision, there was a heavy downpour of rain that washed away the grit out of the gravel road. Mr Nesbitt stated that after the rain, the road surface was very slippery.

⁷ The critical curve speed of the coroner is the theoretical maximum speed a vehicle can negotiate the corner whilst maintaining control.

44. The road is used by local residents, logging trucks and the CFA. Mr Monroe had used the road many times. The homeowner that had assisted lived in the area for 27 years and knew of one other crash on the same corner, which occurred when a logging truck travelling in the same direction rolled over.

Environmental conditions

45. Prior to the collision, the weather had been hot and dry. Visibility was good (it was light) and there were no other vehicles on the road. The road is lined by thick trees in a bushland setting and there was no mention of sun glare by the front seat passenger. DLSC Howie noted sun glare would not have been a problem at 6.15am.

Driver error

46. Mr Monroe had met his fellow CFA members/passengers between 5.30am and 5.45am on 10 January 2010 at the Tolmie Fire Station. During the approximate 18 kilometres travelled prior to the collision, Mr Monroe's passengers did not feel that he was driving at excessive speed for the conditions. There is no other evidence Mr Monroe exceeded the speed limit at anytime during the journey. The highest speed Mr Monroe is known to have reached prior to the collision was 70kph (last recording on the Spider GPS).
47. The CFA volunteers on the Tolmie tanker were aware of their duties on 8 January 2010 and had the opportunity to rest the night beforehand. There is no evidence that Mr Monroe fell asleep while driving.
48. The MCIU collision reconstruction expert LSC Urquhart attended the scene. It appears that as Mr Monroe approached the right hand curve, he moved onto the incorrect side of the road to take a straighter driving line through the curve. As he negotiated the curve, the vehicle was oversteered to the right and the rear near side tray deck above the wheel impacted a tree on the eastern roadside. As a result of this impact, the tanker rotated anticlockwise for a short distance before impacting a second tree on the eastern roadside. The impact with the second tree was on the driver's side section of the cabin. LSC Urquhart determined the physical evidence was consistent with the tanker travelling in a northerly direction along Spring Creek Road when it entered the right hand curve at an excessive speed. As a result, the vehicle has failed to remain on the roadway.

49. Accident reconstruction efforts determined Mr Monroe was travelling at a speed of between 68 and 80kph at the start of the yaw. The critical curve speed for this curve is 80kph. Mr Glen Jennings attended the collision scene on 11 January 2010 with the assistance of a tanker driver, and undertook a series of 'drive throughs' at the relevant curve to determine the speed at which the driver of the tanker with similar specifications could safely negotiate the curve under the same conditions. According to Mr Jennings, the highest speed at which the tanker driver felt comfortable negotiating the curve was approximately 55kph⁸ while slowly accelerating through the curve pursuant to driving instructions. Using these speeds as the maximum 'safe speeds' for the curve, DLSC Howie determined Mr Monroe approached the corner at a speed between 13 and 25kph above the 'safe speed' for the curve.

Signage on Spring Creek Road

50. DLSC Howie stated via email dated 5 March 2014 that there is no sign advising of a safe speed for the relevant corner and that Mr Monroe would not have known the critical curve speed was 80kph. DLSC Howie stated it would be fair that no motorist would know the critical curve speed of a particular corner. DLSC Howie stated his reservations that as Spring Creek Road is a rural back road used by locals as a shortcut, it would be cost and time prohibitive to install a speed advisory sign on every curve. DLSC Howie rather opined that as Mr Monroe frequently drove on this road, he should have been familiar with the curve and the safe speed at which to approach it.
51. DLSC Howie stated in his email dated 15 October 2014 that very few 'new' motorists travel the road and if they did, he believes they would travel at a low speed based on the gravel surface and the unknown factors with the curves. He stated that locals know the road and travel at speeds appropriate for the conditions. He stated that while an advisory sign prior to the curve would be more appropriate, if a sign was erected there, he expressed concerns that it would be necessary to place one on every similar curve in the shire. He questioned whether it is necessary given this incident was the only fatal collision for the road.
52. In an email dated 16 October 2014, DLSC Howie suggested that instead of a sign advising of the curve, that the Council should conduct a risk assessment based on traffic volume and consider signposting a speed limit of 60 or 70kph, rather than the current default 100kph. He stated that as the speed restriction is enforceable, driver compliance would be more likely.

⁸ That is, 55kph on entry to the curve and an exit speed of approximately 60kph.

53. A statement was obtained from Mr Amer Tawfik, Engineering & Works Manager, Mansfield Shire. Mr Tawfik states the average daily traffic is 41 vehicles. He states that Spring Creek Road is graded annually, with the next grade at the time expected in November 2014. He states that the road is maintained by the Mansfield Shire Council.
54. Mr Tawfik explained that for all *sealed* roads where a speed limit is to be applied/reduced/increased, the Council applies to VicRoads with the appropriate justification for the change/addition of a speed limit. VicRoads can then approve or deny the application in line with relevant legislative and engineering requirements. If approved, the Council are responsible for the costs of implementing the change. He states VicRoads will *not* approve a sign posted speed limit for an *unsealed* road due to the variable nature of the road surface. He states ultimately it is up to the motorist to conduct a risk assessment on the road and the prevailing conditions. He states no unsealed roads within the municipality have sign posted speed limits.

RECOMMENDATIONS

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

The significance of Mr Monroe's death on Spring Creek Road should not be diminished due to his death representing only one fatality. Mr Monroe's death rather highlights that even a highly qualified and experienced driver familiar with the road can succumb to its inherent dangers if appropriate caution is not taken. Spring Creek Road has on average 41 vehicles travelling on it per day, some of which are other CFA tankers or large logging trucks, who, by virtue of their relative size and handling capabilities need to exercise continuous due caution around the many bends.

In the interests of preventing future fatalities, I recommend that Mansfield Shire Council, as the entity responsible for Spring Creek Road at Tatong, conduct a risk assessment with the view to placing a sign at the beginning of the road within the municipality (in each direction) to alert drivers of Spring Creek Road's curves and undulations and therefore the dangers therein.

FINDING

Having excluded a number of potential contributing factors to the cause of the collision, including alcohol, drugs, driver fatigue, mechanical failure, driver inexperience or a medical condition, on the totality of the evidence it is difficult to avoid a conclusion that the collision was the result of driver error.

Although there are some shortcomings in the lack of formal training provided by the CFA to Mr Monroe, and a lack of documentation of Mr Monroe's driving experience by the CFA, I find there was sufficient CFA literature and theory information relating to driving and operating CFA vehicles, that the CFA were aware of Mr Monroe's driving training and experience and that Mr Monroe possessed the necessary driving skills to safely control the vehicle.

While it is not possible to determine the precise speed at which the CFA tanker was travelling when Mr Monroe lost control of the vehicle, on the evidence before me I have reached a level of comfortable satisfaction that Mr Munro approached the right hand curve on Spring Creek Road, a road familiar to him, at a speed that proved excessive to safely negotiate the curve in the relevant vehicle. I therefore find that Mr Monroe's death was preventable.

I accept and adopt the medical cause of death as identified by Dr Paul Bedford and find that Mr Hugh Neville Monroe died from multiple injuries post motor vehicle accident (fire truck) in circumstances where I am satisfied that his own actions have contributed to his death, being that he approached the relevant curve on Spring Creek Road at a speed considered to be excessive in the circumstances, causing the CFA tanker to travel wide on the curve, oversteer to the right, causing the ultimate impact into two trees, which resulted in fatal injuries to Mr Monroe and moderate injuries to the other tanker occupants.

Pursuant to section 73(1) of the Coroners Act 2008, I order that this Finding be published on the internet.

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

Mrs Kathryn Monroe

Mansfield Shire Council

VicRoads

Thomson Geer on behalf of Country Fire Authority

Ms Meghan Hoare, Slater & Gordon Lawyers

Ms Karen Alexander, Country Fire Authority

Ms Mary-Anne Bourke (or Ms Bronwyn White), Transport Accident Commission

Ms Lynette Russell, Austin Health

Dr Mark Oakley Browne, Chief Psychiatrist

Detective Leading Senior Constable Ben Howie

Signature:


AUDREY JAMIESON
CORONER
Date: **6 August 2015**

