IN THE CORONERS COURT
OF VICTORIA
AT WANGARATTA

Court Reference: 681 / 2010

FINDING INTO DEATH WITHOUT INQUEST

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

I, SUSAN JANE ARMOUR, Coroner having investigated the death of LYLE SOMERS JEFFERY

without holding an inquest:
find that the identity of the deceased was LYLE SOMERS JEFFERY
born on 22 August 1942
and the death occurred on 18 February 2010
at Maroondah Highway, Mansfield, Victoria, 3722
from:

1 (a) MULTIPLE INJURIES 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]:

1. Mr Lyle Somers Jeffery was a 67 old man who resided with his wife Susan in Euroa, Victoria at the time of his death.

2. At about 8.30am on Thursday, 18 February 2010 Mr Jeffery was travelling east along the Maroondah Highway from Euroa on his 2007 Harley Davidson motorcycle, heading toward his workplace at Mansfield in Victoria. Mr Jeffrey had about four years of motorcycle riding experience and he routinely travelled this route. A fully laden international tipper truck and dog trailer entered Maroondah Highway from a side track from the West Paps pit and travelled in an easterly direction at low speed There is no evidence to suggest that the truck failed to give way to

[1] The circumstances of Mr Jeffrey's death were the subject of an investigation by Leading Senior Constable Paul Storey (24594) of Victoria Police who prepared an Inquest Brief for the Coroner. I have drawn from this investigation in making my factual findings.

Mr Jeffery. As Mr Jeffery approached to within about 10 metres of the rear of the truck he veered to the right and into the oncoming lane of traffic and was immediately struck head on by a Holden Commodore sedan, driven by Ms Mandy Swaney, that was travelling at a speed of about 95kmh in the opposite direction. The truck was not physically involved in the collision and the driver of the truck was not aware that a collision had occurred at that time. The driver of the vehicle immediately behind Ms Swaney's Commodore called 000 and police and emergency services attended. Mr Jeffery was pronounced deceased at the scene and Ms Swaney, the driver of the Commodore, was airlifted to hospital in Melbourne.

3. A single tyre skid mark measuring 49.5 metres in length was observed to commence 57 metres from where the impact occurred. From observations of the tyre mark and scuffing on the rear tyre of the motorcycle Senior Constable Janelle Mehegan of the Victoria Police Major Collision Investigation Unit (MCIU) considered that the mark had been left by the motorcycle whilst under emergency braking. Other marks indicated that the motorcycle had fallen and continued sliding on the right side prior to impact. Senior Constable Mehegan concluded that Mr Jeffery was travelling at approximately 119 km/h when the motorcycle first commenced to skid. She further concluded that Mr Jeffery would have had sufficient time to slow or break to avoid a collision with the truck. Leading Senior Constable Storey was unable to find any evidence of emergency braking on the front tyre of the Harley Davidson motorcycle but there was ample evidence of emergency braking on the rear tyre.

4. Investigating members observed that the Harley Davidson motorcycle, which did not have ABS brakes, was fitted with a "Crampbuster" throttle control device at the time of the incident. Family members confirmed that Mr Jeffrey had fitted the device approximately one year earlier and had used it continuously since then as he had been enthusiastic about the device. It was the opinion of Leading Senior Constable Storey that the Crampbuster device fitted to Mr Jeffery's motorcycle may have interfered with his ability to apply the front brake in emergency braking conditions.

5. No autopsy was performed as the Coroner determined, after advice from the medical investigator, Dr Sarah Parsons, Forensic Pathologist with the Victorian Institute of Forensic Medicine, that a reasonable medical cause of death could be established on the existing information. Dr Parsons performed an external examination of Mr Jeffery at the mortuary, reviewed the circumstances of his death and the post mortem CT scan and provided a written report of her

findings. Dr Parsons considered that Mr Jeffery died as a result of multiple injuries sustained in a motorcycle incident.

6. Toxicological analysis of post-mortem blood samples were negative for alcohol or other commonly encountered drugs or poisons.

7. I find that Lyle Somers Jeffery died from multiple injuries sustained in a motorcycle incident.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008 I make the following comments connected with the death:

1. In light of the circumstances of Mr Jeffery's death, and in the interests of prevention of other deaths in similar circumstances, I asked the Coroners Prevention Unit ("CPU")[2] to undertake a review of any safety issues identified concerning the "Crampbuster" or similar throttle devices.

2. According to the CPU report, and by way of context, the popularity of motorcycle riding has grown considerably in recent years with an increase in the number of older riders taking up riding for the first time, or returning to riding after a significant break. The number of older motorcyclists killed or injured in crashes has increased and, according to VicRoads, in the ten years between 1995 and 2004, the number of motorcyclists aged 30 years or over who were seriously injured or killed doubled from 250 to 555.

3. Advice was sought from VicRoads in relation to the legality of using a Crampbuster device while riding motorcycles in Victoria. The CPU was advised that the Australian Design Rules require a motorcycle throttle to be self closing "upon the release of the hand" and, as the "Crampbuster" would permit this to occur, the device appears to comply with the rules.

4. The CPU liaised with Leading Senior Constable Storey who arranged for the Special Solo Unit of Victoria Police to undertake testing of a standard "Crampbuster" device under emergency

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

braking conditions. That testing revealed that the device could interfere with a rider's ability to apply the front brake, thereby increasing braking distance. The Motorcycle Riders Association of Victoria was not aware of any concerns about such devices but the CPU identified a number of comments posted on U.S. based internet forums where riders raised concerns about the safety of a Crampbuster. However, these sites also contained positive feedback from riders as to their experience of using a Crampbuster.

5. The CPU identified anecdotal evidence that older returning riders may be hesitant to use their front brake, tending to favour the rear brake in the belief that if they were to squeeze the front brake too hard, the motorcycle may slide and skid. Mr Jeffery, however, had been riding on a daily basis for four years and was not a "returning rider".

6. If underbraking was a factor, advanced brake technology (ABS and integrated braking systems) has the potential to improve motorcyclist safety and overcome the reluctance of riders to apply the front wheel brake in an emergency. Road safety agencies currently promote the uptake of both ABS and integrated braking systems and a Regulatory Impact Statement to mandate ABS in all new motorcycles is listed as an action in the first three years under the National Road Safety Strategy 2011-2020.

7. Given the result of the tests conducted by the Special Solo Unit of the Victoria Police that indentified that the "Crampbuster" device may interfere with a motorcyclist's ability to apply the front brake in an emergency braking situation further investigation into the performance of these devices by product safety agencies is warranted.

RECOMMENDATIONS

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

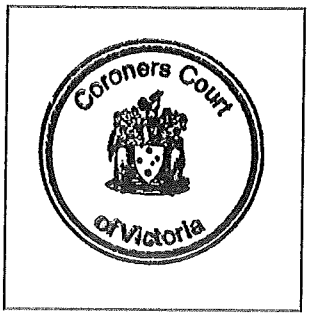
1. I recommend that Consumer Affairs Victoria and the Australian Competition & Consumer Commission take whatever action deemed necessary to address the safety concerns identified in this investigation that relate to the use of "Crampbuster" devices by motorcyclists.

DISTRIBUTION OF FINDING

Apart from the family and the investigator, I direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to the following agencies for their information –

Mr Gary Liddell, Chief Executive – VicRoads
Ms Penny Armytage, Secretary – Department of Justice
Mr Grant Delahoy, President – Motorcycle Rider's Association of Victoria

Signature:



SUSAN JANE ARMOUR
Coroner
Date: 27 March 2012