IN THE CORONERS COURT
OF VICTORIA
AT GEELONG

Court Reference: COR 2013 002868

FINDING INTO DEATH WITHOUT INQUEST

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

I, John Lesser, Corner, having investigated the death of Noel Ian Imbrogno

without holding an inquest:
find that the identity of the deceased was Noel Ian Imbrogno
born on 8 July 1969
and the death occurred on 1 July 2013
at Mercer Street GEELONG 3220 VIC
from:
1a MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (PASSENGER)

*Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Noel Ian Imbrogno was a 43 year old man who died on 1 July 2013 from multiple injuries sustained in a single truck incident.

2. The circumstances of the death of Mr Imbrogno have been fully addressed in the coronial brief compiled by the major collision investigation unit of Victoria Police, which is thorough and comprehensive, and includes statements of relevant witnesses and medical reports. WorkSafe Victoria conducted a joint investigation in relation to the incident, following which the employer of Mr Imbrogno was prosecuted, resulting in a conviction and significant fine.

3. Based on the various witness statements, the following is a brief description of the directly relevant events:
Mr Imbrogno was the front seat passenger in a Mitsubishi rigid delivery truck travelling in a southerly direction on Mercer Street towards the Geelong central business district. The driver, Mr Siva Devath, was a subcontractor who was driving the truck for the first time under the supervision of Mr Imbrogno who had driven it regularly over a long period. According to his statement to police, Mr Devath had worked as a relief driver for Mr Imbrogno's employer, Startrack, for about one month. As he drove south along Mercer Street, approaching the intersection with York Street, he lost control of the vehicle, veered to the left, and collided with a power pole erected on the north-east corner of the intersection. The point of impact was to the front passenger side of the truck, the

damage being extensive. Mr Imbrogno received treatment from the ambulance service, both in the vehicle and after being removed from the vehicle. However, he died from the extensive injuries he sustained.

MAJOR COLLISION INVESTIGATION

4. As part of the police investigation led by Detective Senior Constable C Hayes, in response to an indication by the driver that he had complained to Mr Imbrogno prior to, and again during, the fatal journey about the driver's seat which was wobbling, extensive examinations of the truck were conducted. According to his record of interview, the driver stated that he was trying to pull over when the seat went "on my complete left side", causing him to lose control of the steering and hit the pole. He described that he felt "like that I was about to fall and automatically the hands on my steering turned left and hit the pole" (sic). According to independent witnesses, the speed that the truck was travelling was not a factor. A reconstruction expert gave the opinion that, at the start of a dual tyre skid mark leading to the rear of the truck, the truck's minimum speed was 48 kilometres per hour. None of the witnesses recalled seeing brake lights come on, or heard sounds of braking. However, one witness stated that the truck did slow down before the collision.

5. In about June 2013, another driver replaced Mr Imbrogno for several weeks to drive the truck involved in the collision. He noticed that the driver's seat "moved a bit when you are sitting on it and it moved or lent down a bit to the left side (toward the middle of the cabin) but not a great deal". He stated: "the seat movement did not affect my ability to drive the truck safely", that he did not feel the need to inform anyone about the seat and that did not discuss it with Mr Imbrogno.

6. The conclusion of the mechanical inspection was that, prior to and at the time of impact, the truck would have been classed as unroadworthy due to a frayed driver's seat belt and cracked driver's seat base. The seat base was broken in two locations. The inspector sat on the seat and further observed:

> "The seat felt uncomfortable with it moving around quite a bit. I continued to bounce on the seat further then the seat severely fell to the left. This caused me to jerk on the steering wheel firmly."

7. The inspector then provided the following opinion:

> "In my opinion the driver's seat on this vehicle was very unstable and would not feel correct whilst driving the vehicle. The seat did not fall to the left severely every time I bounced on it. When the seat did this to me whilst bouncing on it, it caught me by surprise and I jerked the steering wheel. In my opinion the driver's seat has contributed to the collision."

8. The driver's seat was the subject of a detailed expert metallurgical examination by a forensic engineer which identified cracks in the metalwork of the pressed metal seat pan and two of the welds in the steel frame of the mechanism. As well, a piece of the scissor assembly and the forward transverse tube that tied the two sides of the scissor assembly were missing. None was found within the cabin of the truck or at the scene of the collision. The expert observed:

> "The articulation of the seat base was assessed and it was found that when sat upon, the seat was unstable and tended to lean to the near side of the cabin. …
> A close examination of the seat assembly revealed that several pre-existing cracks in the pressed metal seat pan had been repair welded … however the age of the repairs could not be determined.
> The scissor mechanism was closely examined and revealed that the forward transverse tube that would normally connect the left and right side scissor bars and also dampen the seat motion had fractured separated from the base assembly. …
> It was noted that the offside end of the tube had suffered a fatigue failure close to the welded connection to the offside scissor bar which appeared to be an old fracture …

The nearside failure occurred through the nearside scissor bar at the point where the bar had been drilled to receive the tube prior to being welded together. It was noted that this failure was also a fatigue crack however it appeared to be a recent failure."

9. The expert concluded in relation to the cause of the incident:

"In view of the above findings it is the writer's opinion that the subject collision occurred as a direct result of the failure of the nearside seat base scissor bar which has caused the driver's seat to roll to the left.

I note that this movement would have been sudden and it is unlikely that the driver would have expected such a motion. It is likely that the driver would have been unable to compensate for the sudden motion and it is unsurprising that he would have pulled on the steering wheel in attempting to stabilise his position on the collapsing seat.

It is the writer's view that the events described in Mr Devath's statement are consistent with the likely failure sequence given the observed failures of the seat base components".

10. In discussing the system of work, the expert opined:

"In this case, I regard the system of work as being unsatisfactory and not consistent with safe work practice. It is the writer's view that had an effective program of defect reporting, inspection and maintenance been employed then the subject failure would not have occurred.

It is evident that the failure of the seat base initiated with the failure of the offside of the forward tube which had occurred at some point in time prior to the failure of the near side of the tube which was almost certainly the event that triggered the sudden collapse of the seat. Had the initial failure been identified and corrected in a timely fashion, the second catastrophic failure would not have occurred".

11. Based on comments attributed by Mr Devath in his statement to Mr Imbrogno about the seat's stability, the expert went on to surmise:

"... it would appear that Mr Imbrogno may have become used to driving the truck despite the stability of the seat being impaired by the initial (offside) failure. In the event that this was the case, there would appear to have been a breakdown in the defect reporting/rectification procedure which relied on a verbal communication between the driver, his supervisor and the external maintenance provider. On this basis, it would appear that in this case at least, the culture relating to defect reporting was probably weak which may be regarded principally as a management shortcoming".

12. The expert's conclusion was:

"In view of the above findings it is the writer's view that the subject collision was the result of the initial failure of the offside of the seat base which remained unrepaired for some period of time and was the precursor to the subsequent catastrophic failure of the nearside seat base and the sudden collapse of the seat which inevitably caused the driver to lose control of steering the truck".

13. A review of maintenance records relating to the truck showed that, on 7 February 2012, one of five issues noted as requiring attention was "drivers seat base cracked" (sic). The truck was serviced twice more by the same firm, but there is no record of the driver's seat fault being rectified. In early 2013, a different firm serviced the truck twice, however there was no record of repairs relating to the seat. Startrack's operations supervisor reported to police his recollection of a conversation with Mr Imbrogno in around March 2013 in relation to the faulty driver's seat. To the best of his memory, he reported:

"Noel told me there was a problem with the seat in his truck, that it was wobbly, and that his truck was a piece of shit. I know I had the truck sent to Fuso to be looked at and, I can't

COMMENTS

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

18. The untimely death of Mr Imbrogno tragically resulted from the truck in which he was a passenger colliding with a pole at the intersection of a street near the centre of Geelong. Although a subcontractor to Mr Imbrogno's employer, Startrack, the driver of the truck had worked for Startrack on a regular basis. Mr Imbrogno was a regular driver of the truck. Mr Imbrogno's death was the subject of extensive investigations by the WorkSafe Victoria and the Victoria Police major collision investigation unit. Based on those investigations, it is clear that Mr Imbrogno had previously notified his employer about the driver's seat of the truck. There is no clear evidence that the driver's seat was ever satisfactorily repaired or made safe. From the account given by the driver, which was consistent with the investigator's findings, the immediate cause of the collision was the collapse of the driver's seat in circumstances in which the driver, who was in the process of changing lanes to the left, lost control of the steering and drove into the pole at the intersection.

19. The circumstances of the death of Mr Imbrogno focus the attention of this investigation to the importance of heavy vehicles used on Victorian roads being regularly and properly inspected, maintained and, as necessary, repaired or rectified to ensure they are both roadworthy, in the legal sense, and in a safe driving condition. This requirement affects not only the driver and passengers of the heavy vehicles, but all road users who indirectly or directly may be affected by the operation of the heavy vehicles. The conclusions of the expert investigation in this case clearly point to a failure of Startrack's system of work in relation to reporting and rectifying vehicle faults in a timely manner. The coroner notes that appropriately, since the incident, a written reporting system has been commenced in an effort to avoid any similar failures in the future.

20. At the request of the Coroner, the Coroner's Prevention Unit (CPU) undertook a search to identify deaths in Victoria of people involved in truck collisions because of mechanical faults in the truck causing the driver to lose control. A search of the National Coronial Information System (NCIS) from 1 July 2000 was undertaken to identify relevant deaths, as well as a review of the Victorian database of coronial findings containing comments or recommendations in similar deaths between 1 January 2000 and 1 July 2015. A total of 12 relevant incidents was identified - seven involved faulty brakes, three involved collisions where wheel assemblies dislodged from a truck, and two occurred when diesel fuel escaped from the truck's fuel system causing a car carrying driver and passenger to lose control by skidding on spilt diesel fuel and crashing. No case similar to this was identified. The report properly noted:

> "The importance of periodic and routine maintenance and servicing of heavy vehicles cannot be overstated and has been stated in previous coronial findings".

RECOMMENDATIONS

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

1. Startrack, Mr Imbrogno's employer, undertake a periodic review of its system of work in relation to the reporting and rectification of vehicle faults, periodic and routine maintenance and servicing of its heavy vehicles, and the general safety of its vehicle fleet.

2. Startrack, Mr Imbrogno's employer, undertake a periodic review of its system of work in relation to the induction of new employees and regular training of its workforce, including regularly employed subcontractors, in the procedures relating to the inspection and reporting of vehicle faults to management.

3. Using Mr Imbrogno's death as an example, VicRoads review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

4. Using Mr Imbrogno's death as an example, WorkSafe review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

5. Using Mr Imbrogno's death as an example, the National Heavy Vehicle Regulator review its publications and information distribution to heavy vehicle operators to promote industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

6. Using Mr Imbrogno's death as an example, the Insurance Council of Australia review its Code of Practice, publications and information distribution to heavy vehicle operators to ensure that, in relation to insurance contracts, it encourages industry awareness of the importance of periodic and routine maintenance and servicing of heavy vehicles, the importance of having and regularly reviewing a safe system of work in relation to procedures relating to the inspection and reporting, and the repair/rectification, of vehicle faults, and the inherent dangers of the failure to do so.

FINDING

I find that Mr Imbrogno died on 1 July 2013 at Mercer Street Geelong and that the cause of his death was multiple injuries sustained in a motor vehicle incident (passenger).

I direct that a copy of this finding be provided to the following:
Mr Neil Imbrogno, Mr Imbrogno's father
The Honourable L Donnellan, Minister for Roads and Road Safety
Mr J Merritt, Chief Executive, VicRoads
Ms C Amies, Chief Executive, WorkSafe Victoria
Mr S Petroccitto, Chief Executive Officer, the National Heavy Vehicle Regulator
Mr R Whelan, Chief Executive Officer, Insurance Council of Australia.

Detective Senior Constable C Hayes, the investigating member

* Pursuant to rule 64(3), I order that the following be published on the internet:

The finding

Signature:

30 OCTOBER 2015

Coroners Court of Victoria