IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 0442**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**STEVEN CHRISTOPHER STEWART**
Date of birth:	**8 SEPTEMBER 1963**
Date of death:	**24 JANUARY 2019**
Cause of death:	**INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER)**
Place of death:	**LAVER STREET, KEW, VICTORIA 3101**

HIS HONOUR:

BACKGROUND

1. Steven Christopher Stewart was born on 8 September 1963 and was 55 years old at the time of his death. Steven lived in Aspendale Gardens, Victoria, with his partner, Susan Rose living nearby in Chelsea, Victoria.

2. Steven worked as a truck driver for Bingo Industries Limited.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Steven's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and resulted, directly or indirectly, from an accident or injury.[1]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*
[3] *Keown v Khan* (1999) 1 VR 69.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Steven was visually identified by his partner, Susan Rose, on 29 January 2019. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 25 January 2019, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Steven's body and provided a written report dated 28 January 2019, concluding a reasonable cause of death to be "I(a) Injuries sustained in a motor vehicle incident (driver)". I accept his opinion in relation to the cause of death.

13. Toxicological analysis of post-mortem specimens did not detect alcohol, common drugs or poisons.

[4] (1938) 60 CLR 336.

14. Dr Lynch noted that the post-mortem CT scan revealed that Steven had suffered bilateral rib fractures, bilateral pneumothoraces[5] and a left haemothorax.[6]

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 24 January 2019, at about 1.30pm, Steven drove his 2017 orange four axle Isuzu skip truck (flat bed with hook) south on Hodgson Street, Kew. On stopping the vehicle to collect a skip bin on the roadway outside of 24 Hodgson Street, Kew, he positioned the truck facing downhill. After exiting the vehicle, it began to roll downhill. Steven ran and climbed back onto the exterior of the cab as the vehicle mounted the curb on the western side of the road colliding with wooden and concrete fences before coming to a stop; resting against an outbuilding and fence at 26 Laver Street, Kew. Steven was compressed between the vehicle and the concrete fence before falling to the ground by the driver's side of the vehicle.

16. On hearing the loud bang from the collision, a neighbour and a tradesperson undertaking work at a nearby property ran to the scene and saw a man subsequently identified as Steven lying on the ground near the truck. The tradesperson immediately contacted emergency services. A short time later, members from the Melbourne Fire Brigade (**MFB**), Ambulance Victoria and Victoria Police arrived at the scene. After stabilising the truck and moving Steven to a safer location, the ambulance paramedics commenced cardiopulmonary resuscitation. Despite emergency services' best efforts, Steven succumbed to the injuries he sustained. He was declared deceased at the scene.

Further police investigation

17. Senior Constable Brett Truscott of Nunawading Highway Patrol reviewed the collision scene. On inspection of the vehicle, he noted that the truck had sustained damage to the front and driver's side panels of the cabin; reporting that the damage was consistent with the truck rolling down the hill and impacting with fences and outbuildings of properties.

18. Senior Constable Truscott advised that Hodgson Street has a bitumen surface that can be driven in both a north and south direction. There is no dividing line in the middle of the road and the speed limit is 50km/hr. He noted that on either side of the road there are large trees, bluestone kerbs and residential properties and that Hodgson Street declines moderately from Studley Park Road before levelling out south of the collision scene.

[5] A pneumothorax is a medical condition where the lung collapses when air enters the space around the lungs. A common cause for this occurring is any blunt or penetrating injury to the chest.
[6] Haemothorax occurs when blood collects between your chest wall and your lungs. Haemothoraces are usually caused by an injury.

19. Senior Constable Truscott stated that on the day of the incident the weather was clear and sunny, with Hodgson Street being dry due to their being no rainfall.

20. The vehicle was inspected by Andrew Stroud, Transport Safety Services Officer – Automotive Technician of Roads Corporation Victoria, and Anthony Harris, VicRoads Officer. Mr Stroud, a fully qualified motor mechanic and qualified in Licensed Vehicle Testing, Heaving Vehicle Inspections, Vehicle Body Structural Awareness and Hybrid Vehicle Safety, stated that when the truck was recovered to the roadway the park brake was operated, by way of engaging and nonengaging. When operated in this way, he said that he found the park brake operation to be in a serviceable condition.

21. Mr Stroud also reported that on speaking with Brendan Holowiuk, Leading Fire Fighter, Carlton Fire Station, Mr Holowiuk identified that upon arriving at the scene he entered the truck's cabin and observed that the vehicle was still running, in neutral and that the park brake lever was not engaged. Mr Holowiuk advised that he applied the park brake lever and switched the ignition off prior to exiting the cabin.

WorkSafe investigation

22. WorkSafe Victoria attended the scene and undertook their own investigation. On 4 February 2019, I was informed by Peter Collins, Investigations Manager, Enforcement Group of WorkSafe Victoria, that as a result of Steven's death, Bingo Industries Limited was being investigated for possible breaches of the *Occupational Health and Safety Act* 2004.

23. On 12 October 2020, I was advised by Georgia Daniel, Coronial Lawyer – Administrative Review, Advice and Coronial Support, Legal and Governance Division, Victorian WorkCover Authority (**VWA**),[7] that due to there being insufficient evidence, the VWA did not commence a prosecution against any party in relation to Steven's death.

FINDINGS

24. Having investigated the death of Steven Christopher Stewart and having considered all of the available evidence, I am satisfied that no further investigation is required.

25. On the basis of the available evidence, I am satisfied to the requisite standard that Steven died from the injuries he sustained after his truck rolled forward and subsequently

[7] WorkSafe Victoria is the trading name of the Victorian WorkCover Authority.

compressed him between the vehicle's cabin and a concrete fence. I am satisfied that Steven's inaction of applying the vehicle's hand and park brake was an error in judgement.

26. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Steven Christopher Stewart, born 8 September 1963;

    (b) that Steven Christopher Stewart died on 24 January 2019, on Laver Street, Kew, from injuries he sustained in a motor vehicle incident where he was the driver; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

27. I convey my sincerest sympathy to Steven's family and friends.

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

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

    (a) Steven Stewart's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 29 January 2021