IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1727

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr R
Date of birth:	[redacted] 1982
Date of death:	6 April 2019
Cause of death:	*Multiple injuries (motor vehicle impact – driver)*
Place of death:	Sandy Creek Road, Sandy Creek, Victoria

Introduction

1. Mr R,[1] born [redacted] 1982, was 36 years of age at the time of his death. He lived in [redacted] with his wife, Mrs R and their young son, Master R.

2. On the afternoon of Saturday 6 April 2019, Mr R died as a result of injuries he sustained in a motor vehicle collision on Sandy Creek Road, Sandy Creek, Victoria.

The Coronial Investigation

3. Mr R's death was reported to the coroner as it appeared to fall within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). A reportable death includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury.

4. A coroner independently investigates reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

5. Victoria Police assigned Leading Senior Constable Paul Marshall from the Wodonga Highway Patrol (**LSC Marshall**) to be the Coroner's Investigator for the investigation into Mr R's death. LSC Marshall conducted inquiries on my behalf,[3] including taking statements from witnesses and compiling a coronial brief of evidence. The brief contains statements from Mr T (whose property Mr R was working at on the morning of the accident), Mrs R, nearby residents who attended the scene of the accident, the forensic pathologist who performed the autopsy and LSC Marshall, as well as other relevant documentation.

6. In addition to the above material, I sought additional information from LSC Marshall in relation to the restraint of the equipment loaded on the rear of Mr R's vehicle at the time of the collision and LSC Marshall's view regarding the appropriate driving speed in the conditions. LSC Marshall's response to this request is contained in a supplementary

[1] Referred to as 'Mr R' unless more formality is required.
[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.
[3] The carriage of the investigation was transferred from Deputy State Coroner English.

statement dated 30 July 2020. In the latter stage of the investigation, I sought further advice from LSC Marshall with respect to the excavator restraint as well as information to assist with my recommendation for an advisory speed sign.

7. I have based this finding on the evidence contained in the coronial brief and the supplementary statement and information from LSC Marshall referred to above.

8. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required.

9. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Background

10. Mr R was a plumber and ran his own plumbing and draining business. He also had experience in crane driving and machine operation.[4] His wife said it was common for him to work on weekends, especially if he was assisting friends.

11. Mr R was the holder of a full current Australian Capital Territory heavy vehicle licence which was issued in October 2017. He owned a white 1996 Mitsubishi tray truck [redacted] registered to his business which was the vehicle involved in the collision. According to his ACT traffic history record, he received a speeding fine on 21 January 2019 *(exceeding the speed by less than 15 km/H)*.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On Saturday 6 April 2019 Mr R worked at Mr T's property at [redacted], Sandy Creek, who he had known for about 20 years. Mr R was to assist Mr T with plumbing as well as excavation works for the foundations of a new home.

13. According to the police summary, Mr R had worked at Mr T's property for approximately one week and travelled the route on Sandy Creek Road multiple times during that period. He had apparently been transporting equipment to and from the property on the rear of his truck.[5]

14. At about 8am on Saturday 6 April 2019, Mr R arrived at Mr T's property. He unloaded a piece of heavy equipment machinery ('Caterpillar' 267B Multi Terrain Skid-Steer

[4] Statement of Mr T dated 8 April 2019.
[5] Summary prepared by police.

Loader) **(the loader)** from the tray of his truck and the two men started work. Mr R and Mr T stopping work at about 2.30pm and started to pack up. Mr T helped Mr R get the loader back onto the tray of the truck for Mr R to take with him. Mr T said that the *ramps* were placed under the loader on the tray and Mr R placed a bucket on them *to keep them secure.*

15. Between approximately 2.40pm and 3.00pm on 6 April 2019,[6] Mr R left Mr T's property to travel to Yackandandah.[7] Mr T said in relation to Mr R, *he was in a good mood, looking forward to seeing his son and family at the function that evening.*

16. Mr T drove his truck in a northerly direction on Sandy Creek Road, towards the intersection of Lockharts Gap Road. This section of Sandy Creek Road has a 100km/h default speed limit and a paved bitumen surface.

17. Ms L, a witness and resident of Cemetery Lane, Sandy Creek, said that her daughter heard a *bang* about 3.15pm. Her daughter also gave a statement and said that she recalled hearing two *smaller bangs* followed by a *large bang.* Ms L approached the scene and observed a truck on fire. She contacted emergency services from her home and returned to the scene. She was aware there was a person in the truck but was unable to get close enough to assist due to the fire.

18. Emergency services personal attended the scene shortly thereafter. Local residents and the Country Fire Authority worked to extinguish the fire. Tragically, the driver of the vehicle, later identified as Mr R, received injuries that were not compatible with life and he was unable to be assisted.

Police investigation

19. Police including LSC Marshall attended the scene of the collision at approximately 3.55pm. On arrival police observed the truck with a *Bobcat* on the rear on fire.

20. LSC Marshall examined the scene and liaised with fire crew. LSC Marshall noted that the truck had struck a tree on the eastern side of the road with significant force. LSC Marshall examined the road surface in the vicinity of the collision and stated,

There were skid and yule marks on the road that came from a culvert on the western edge of the road. In the culvert there were clearly signs of the passenger side wheels of the truck had been running along in there and digging the dirt.

[6] In his statement Mr T said that Mr R left at about 3pm however the summary prepared by police states that Mr R left the property at about 2.40pm.
[7] Statement of LSC Paul Marshall dated 7 May 2020.

21. LSC Marshall spoke with Mr T who attended the scene. Mr T provided LSC Marshall with information to assist in identifying Mr R.

22. LSC Marshall liaised with police mechanics and investigators from the Major Collision Investigation Unit and it was determined that a mechanical inspection was not appropriate due to the extent of the fire damage to the vehicle.

23. Once the fire was extinguished, police inspected the truck at the scene. They identified that the loader did not appear to be secured to the tray of the truck.[8] There was damage to the front of the tray and cabin of the truck, consistent with the loader having moved and impacted both areas. The truck cabin was also disconnected from the chassis of the vehicle. According to police, a 'jerry can' and chainsaw were located behind the driver's seat.[9] LSC Marshall considered that the steering and brakes were operational at the time of the collision however their effectiveness could not be determined.[10]

24. LSC Marshall noted that there was a sweeping corner approximately 175 metres from the collision point, which Mr R's truck would have taken as a left-hand bend.

25. Based on the evidence at the scene, LSC Marshall formulated a detailed account of the events immediately preceding the collision. LSC Marshall considered that Mr R's vehicle went wide (to the right) of the left hand bend in the road. He theorised that Mr R then *over-corrected,* steering to the left so that the passenger side wheels went off the road and down into a 'culvert'[11] on the left (western) side of the road. LSC Marshall noted that the drop of the side of the vehicle caused the loader to shift to the left side of the tray. The movement of the loader appears to have caused two metal pins holding the side wall of the tray on to sheer off. It also caused the ramps on the tray to lodge beneath one of the loader's tracks.[12] LSC Marshall found *rolling impressions and dug up dirt* in the culvert, indicating that Mr R had attempted to steer the truck. LSC Marshall noted that on the road next to the culvert there were marks from the driver's side tyres which showed that the wheels left the ground. He further observed that, *Where the tyres had regained contact with the road surface there were rolling yule marks and braking skid marks. Because the skid steer* [loader] *in the tray had moved*

[8] LSC Marshall said *ratchet straps* were located on the ground, however he believes they were stored inside a toolbox at the time of collision.
[9] Coronial brief, photograph list, photograph 34.
[10] Summary prepared by police.
[11] Photographic evidence contained in the brief shows this has the appearance of a dirt ditch.
[12] In his summary LSC Marshall noted that the metal surface of the steel ramp against the surface of the tray would have reduced friction and enabled the loader to *move more freely in the tray.*

this had shifted all the weight of the truck into the front wheels, causing the yule marks on the road.

...

The tyre marks on the road indicated that [Mr R] *had tried to steer the truck straight however because of the loss of traction and very little braking capacity the truck ended up colliding down with a tree, down an embankment on the opposite side of the road.*

26. According to LSC Marshall's calculations, the truck had an approximate load capacity of 5000 kgs (GVM – tare) and the operational weight of the loader was 4250 kgs. LSC Marshall said when weighed at the scene the combined weight of the loader and ramps on the tray was 4680 kgs. These calculations suggest that the truck was close to its load capacity at the time of the collision.

27. LSC Marshall conducted further investigation in relation to the restraint of the loader and was not able to determine whether Mr R usually secured his equipment or the method of restraint used. LSC Marshall asked Mr T whether he recalled Mr R using chains or straps in the past and Mr T told him, *he didn't believe he had seen anything used.* Mr T also said in his statement that he didn't see Mr R *strap or chain the bobcat onto the truck* on the day of the accident. In LSC Marshall's view, it was possible that the ratchet straps located at the scene were used to secure the loader on previous occasions. However, he considered that even if the straps were applied, due to the design of the truck, they would not have sufficiently restrained the loader.[13] LSC Marshall also noted there were no *tie down* points in or on the tray of the truck and therefore any strap would likely have been positioned over the sides of the tray, causing friction and wear on the straps.

28. LSC Marshall found no evidence that the truck exceeded the 100km/h speed limit. However, he considered a lower speed of 80 km/h to be an appropriate speed for a heavy vehicle to navigate the relevant left-hand bend near the location of the collision. He noted that there were other corners on that section of Sandy Creek Road with a sign posted advisory speed limit of 80 km/h, however there was no sign at that bend.

[13] LSC Marshall also said that the National Transport Commission's Load Restraint Guide 2018 suggests that the *most appropriate ...load restraint for an excavator is that it is tied down to found points to stop any movement.* The Guide extract provided by LSC Marshall has suggested methods for the restraint of *equipment on metal tracks or wheels* and *vehicles and equipment on rubber tyres or tracks.*

29. LSC Marshall considered based on the position that Mr R was found it *highly possible* that he was not wearing a seatbelt at the time of the collision however due to the fire damage to the vehicle this could not be conclusively determined.

30. Mr R's mobile phone download was examined by police and there was no evidence found to suggest he was using his phone at the time of the collision.

31. LSC Marshall noted that since the accident maintenance work has been undertaken to fill the culvert next to the road.

32. LSC Marshall ultimately concluded that the weight of the loader and ramps, combined with the movement of the unrestrained loader in the tray of the truck and the speed of the truck were causal factors in the collision. He summarised that in his opinion,

...the factors contributing to the collision are too much speed into the left-hand corner for the type and weight of vehicle, the unrestrained excavator and it's added weight and it now having a higher centre of gravity...Compounded by the fact that the excavator was not secured in the back and moved around causing greater instability of the truck and less ability to control it.[14]

IDENTITY

33. On 16 April 2019, having considered the Police report of death (Police Form 83), Victorian Institute of Forensic Medicine (**VIFM**) Identification Report and the Scientist's report as to DNA analysis, Coroner Darren Bracken made a determination pursuant to section 24 of the Act identifying the Deceased as Mr R born [redacted] 1982.

34. Identity is not in dispute and required no further investigation.

CAUSE OF DEATH

35. On 10 April 2019, Dr Malcolm Dodd, a specialist forensic pathologist practising at the VIFM, performed an autopsy and provided a written report dated 17 July 2019. In that report, Dr Dodd concluded that a reasonable cause of Mr R's death was *'Multiple injuries (motor vehicle impact – driver)'*.

36. Dr Dodd noted that there was no evidence of smoke or gas inhalation indicating that Mr R's death was caused primarily by injuries sustained at the moment of impact. The

[14] Summary prepared by police.

external examination and computed tomography (CT) scan showed numerous fractures and fire related injury.

37. Dr Dodd found evidence of natural disease of the heart:

- mild cardiomegaly (enlarged heart) with a dilated right ventricular chamber;
- mild stenosis (narrowing) of the left coronary artery; and
- mild focal myocarditis (inflammation of the heart muscle).

38. Dr Dodd noted that although the above findings raise the *possibility* of a primary medical event, this could not be proven.

39. Toxicological analysis identified no alcohol, common drugs or poisons in Mr R's system.

40. I accept and adopt Dr Dodd's opinion as to Mr R's medical cause of death.

Conclusion

41. There is no evidence to suggest this was anything other than a tragic accident.

42. Although there is evidence of natural disease that raises the *possibility* that Mr R suffered from a cardiac episode proximate to the collision I am unable to make a finding that this caused or contributed to the accident. I note evidence that Mr R took active evasive action to avoid the collision, which suggests a level of responsiveness and driving capacity not consistent with him suffering from a medical event. The evidence suggests it was the combination of the external factors identified by the Coroner's Investigator that contributed to his losing control of the vehicle and ultimately colliding with the tree.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

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

1. That the Indigo Shire Council consider installing advisory speed sign(s) at an appropriate location at the bend near the intersection of Sandy Creek Road and Reserve Road, Sandy Creek, recommending a maximum speed limit of 80 km/h.

FINDINGS

44. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Act that Mr R, born [redacted] 1982, died on 6 April 2019 at Sandy Creek Road, Sandy Creek, Victoria, from '*Multiple injuries (motor vehicle impact – driver)*', in the circumstances described above.

45. I convey my sincere condolences to Mr R's family for their loss and acknowledge the tragic circumstances in which his death occurred.

46. Pursuant to rule 68(2) of the *Coroners Court Rules 2019*, I direct that the redacted finding be published on the internet.

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

Mrs R, senior next of kin

Leading Senior Constable Paul Marshall, Victoria Police, Coroner's Investigator

Indigo Shire Council

Signature:

SARAH GEBERT
CORONER

Date: 28 January 2021