



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007253

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Dimitra Dubrow
Deceased:	Raymond James Trimby
Date of birth:	14 October 1948
Date of death:	20 December 2022
Cause of death:	1a: chest injuries sustained in a quad bike incident (driver)
Place of death:	380 Tomahawk Creek Road, Pirron Yallock, Victoria, 3249
Keywords:	Quad bike, workplace death

INTRODUCTION

1. On 20 December 2022, Raymond James Trimby was 74 years old when he died from chest injuries sustained a quad bike accident while mustering cattle on a dairy farm owned by his daughter and son-in-law.
2. Raymond was not an employee but attended the farm regularly to assist as “*he could not accept retirement*”.

THE CORONIAL INVESTIGATION

3. Raymond’s death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
4. The role of a coroner is to independently investigate 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.
5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
6. Judicial Registrar Katherine Lorenz, then coroner, initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024 and following Judicial Registrar Lorenz’s departure.
7. Victoria Police assigned an officer to be the Coronal Investigator for the investigation of Raymond's death. The Coronal Investigator conducted initial enquiries on the Court’s behalf, including taking statements from witnesses.
8. Section 7 of the Act requires that coroners liaise with other investigating bodies to avoid unnecessary duplication of inquiries and investigations. To this effect, the coronial investigation was put on hold while WorkSafe Victoria investigated the death.

9. The coronial investigation resumed in September 2024 after WorkSafe notified the court that they had decided to take no further action following a comprehensive investigation into the death and the issuing of improvement notices. The Court was assisted by provision of the WorkSafe brief of evidence.
10. The Court was also assisted by the Coroners Prevention Unit (**CPU**) who provided advice and information about other quad bike deaths in Victoria. The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death.
11. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety, such as in this case.
12. This finding draws on the totality of the coronial investigation into the death of Raymond James Trimby. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On 20 December 2022, at about 9am, Raymond attended the farm and was mustering cattle on a quad bike. Raymond was not wearing a helmet at the time.
14. The terrain in the area was rough and uneven with a slight incline.
15. At about 10am, a worker saw a quad bike on its side 100m from where he was working and called Raymond's son-in-law.
16. They both attended and found Raymond unresponsive underneath the quad bike. Together, they extricated Raymond from underneath the quad bike and called Triple Zero.

¹ 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.

17. The worker performed CPR while the son-in-law cleared a path for paramedics to attend.
18. Paramedics from Ambulance Victoria, police, and Fire Rescue Victoria attended soon after and took over resuscitative efforts.
19. Unfortunately, Raymond was deceased and could not be revived.
20. Examination of the scene by police noted tyre marks on the dirt track and in the grass verge by the quad bike. The tyre marks suggested that the quad bike had come off the road, through an electric fence, and came to a rest within the paddock.
21. Attended police members provide an opinion that this may have indicated that Raymond lost control of quad bike while mustering cattle which resulted in a partial roll over.
22. Subsequent inspection of the quad bike found it to be in good condition with no significant faults. There was a finding that two tyres had lower pressure than recommended.

Identity of the deceased

23. On 20 December 2022, Raymond James Trimby, born 14 October 1948, was visually identified by a relative, who completed a statement of identification.
24. Identity is not in dispute and requires no further investigation.

Medical cause of death

25. On 21 December 2022, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination and provided a written report of the findings.
26. The examination showed abrasions and bruises on multiple parts of the body, as well as congestion of the face. No *unexpected* signs of trauma were seen.
27. A CT scan showed significant chest injuries including multiple fractures, air in the heart and liver, and *haemothorax* (blood in the space around the lung). There were no skull or cervical spine fractures, and no evidence of intracranial haemorrhage.
28. Toxicological analysis of postmortem samples detected paracetamol only. Alcohol was not detected nor any other common drugs or poisons.

29. Dr Young provided an opinion that the medical cause of death was *1(a) chest injuries sustained in a quad bike incident (driver)*.
30. I accept Dr Young's opinion.

WORKSAFE INVESTIGATION

31. WorkSafe Inspectors attended the scene on the day of the accident. An Inspector noted that there were three quad bikes and a side by side buggy available for use by employees. They noted that all quad bikes had roll over protection and helmets were provided.
32. The Inspector identified, among other things, that there was no training, instruction, or information in relation to the use of quad bikes at the farm.
33. The Inspector issued an Improvement Notice to ensure that employees who use quad bikes are trained and provided with information and instruction. The Improvement Notice was accompanied by the relevant WorkSafe guidance regarding quad bikes on farms.
34. On 21 February 2023, Inspectors returned to the farm. They noted that there was now an induction training record for quad bikes, a policy on the safe use of quad bikes, and a Standard Operating Procedure (SOP) for using quad bikes.
35. Inspectors noted that employees were operating quad bikes at the time of the inspection and were all wearing helmets.
36. The Inspector was informed that employees had undertaken the training for quad bike use in the workplace and that a pre-start check of the quad bikes was conducted each day prior to use.
37. Another Inspector stated that based on their observations and information received, they determined that the Improvement Notice had been complied with.

CPU REVIEW OF QUAD BIKE ACCIDENTS

38. The CPU identified 25 quad bike deaths between 1 January 2015 and 31 December 2024 in Victoria. The deaths were evenly distributed over this period with no clear increasing nor decreasing trend.

39. The CPU defined quad bike with reference to the Australian Competition and Consumer Commission (ACCC) standards as an off-road motorised vehicle that travels on four wheels with a seat designed to be straddled by the operator, and handlebars for steering control.²
40. Utility terrain vehicles (UTVs) and side-by-side vehicles (SSVs) were not examined as part of the review.³
41. The CPU found that 14 of the 25 fatalities occurred during work. Where known (18 deaths), only one case was wearing a helmet at the time. Where known (12 deaths), only one case was riding a quad bike with a roll over protection device.
42. The CPU drew attention to the four previous coronial comments from Victoria coroners regarding quad bike safety in the last 10 years. These are all published on the Court's website.⁴

Roll over protection devices

43. In October 2019, the Federal Government accepted the ACCC recommendation to introduce a new mandatory safety standard for quad bikes,⁵ applying to new and imported second-hand vehicles.
44. Stage 1 came into effect on 11 October 2020 and required that:
 - a) All quad bikes must meet the specified requirements of either the US quad bike Standard, ANSI/SVIA 1-2017 or the EN 15997:2011 Standard.
 - b) All quad bikes must be tested for static stability using a tilt table test and display the angle at which it tips on to two wheels on a hang tag.
 - c) All quad bikes have a durable label affixed, visible and legible when the quad bike is in operation, alerting the operator to the risk of rollover and must include rollover safety information in the owner's manual.
45. Stage 2 came into effect on 11 October 2021 and required that:

² ACCC Product Safety, "Quad bikes mandatory standard", <<https://www.productsafety.gov.au/business/search-mandatory-standards/quad-bikes-mandatory-standard>>.

³ UTVs and SSVs have a 'sit in' side-by-side seating arrangement so that the vehicle can be used by the operator and passengers. They typically have steering wheels, seatbelts and rollover protection structures that enclose the driver.

⁴ [COR 2017 004821](#); [COR 2018 005660](#); [COR 2020 003507](#); [COR 2022 005249](#).

⁵ Australian Competition and Consumer Commission, "Major step forward in quad bike safety from 11 October", <<https://www.accc.gov.au/media-release/major-step-forward-in-quad-bike-safety-from-11-october>>.

- a) All general use model quad bikes must have an operator protection device (OPD) that is either:
 - i. fitted into the bike; or
 - ii. integrated into its design.
 - b) All general use model quad bikes must meet the minimum stability requirements of:
 - i. lateral stability – a minimum tilt table ratio (**TTR**) of 0.55
 - ii. front and rear longitudinal pitch stability – a minimum TTR of 0.8
46. With the average age of quad bikes in Australia being 10 years,⁶ the CPU acknowledged that it would take some time for most quad bikes to have these mandatory standards.
47. The CPU considered that any consideration of further interventions is limited until the impacts of these standards on fatalities and injuries is known.

Helmets and training

48. Mandating helmet use on quad bikes has been the subject of coronial recommendations nationally and was mentioned in the ACCC's quad bike safety final recommendation to the minister report. ACCC's report referenced the SafeWork NSW quad bike safety improvement program which, amongst other things, offered a rebate towards the purchase of compliant helmets and provided a free training course.⁷ It was noted that despite this scheme, and similar schemes in other states, fatalities and injuries continue to occur.
49. Recommendations made by a Queensland coroner following the deaths of nine people included that all quad bike operators on private property are required to wear safety helmets.⁸ However, the legislated mandatory use of helmets only applies when on roads and road related areas, which is not where most fatalities occur.

⁶ Australian Competition and Consumer Commission, "Quad bike safety – Final Recommendation to the Minister", <https://consultation.accc.gov.au/product-safety/quad-bike-safety-standard-exposure-draft/supporting_documents/Quad%20bike%20safety%20%20Final%20Recommendation%20to%20the%20Minister.pdf>.

⁷ Australian Competition and Consumer Commission, "Quad bike safety – Final Recommendation to the Minister", <https://consultation.accc.gov.au/product-safety/quad-bike-safety-standard-exposure-draft/supporting_documents/Quad%20bike%20safety%20%20Final%20Recommendation%20to%20the%20Minister.pdf>, 35.

⁸ Queensland Government, "Inquest into nine deaths caused by quad bike accidents", <www8.austlii.edu.au/au/other/qlld/QLdCorCResp/2014/17.pdf>.

FINDINGS AND CONCLUSION

50. Pursuant to section 67(1) of the Act I make the following findings:
- a) the identity of the deceased was Raymond James Trimby, born 14 October 1948;
 - b) the death occurred on 20 December 2022 at 380 Tomahawk Creek Road, Pirron Yallock, Victoria, 3249, from *chest injuries sustained in a quad bike incident (driver)*; and,
 - c) the death occurred in the circumstances described above.
51. While it is noted that Raymond was not wearing a helmet, I do not consider that this would have made a difference in this case because the fatal injuries were confined to the chest and there was no evidence of injury to the head. Nonetheless, I reiterate the importance of helmet use when operating quad bikes.
52. I also note that the quad bike, and all quad bikes at the farm, had rollover protection.
53. This case then highlights the significant residual risks of quad bikes despite appropriate safety measures, the dangers of which are generally known and were known, or ought to be known.
54. I am satisfied that the actions taken by the farm owners following the WorkSafe investigation and inspections have obviated the need for further coronial recommendations and ensure that the risks associated with quad bike use are known to employees.

I convey my sincere condolences to Raymond's family for their loss.

Pursuant to section 73 (1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Lorna Trimby, Senior Next of Kin

Victoria Workcover Authority (WorkSafe Victoria), c/o Wisewould Mahoney Lawyers

Senior Constable Rebecca Humphreys, Coronial Investigator

Australian Competition and Consumer Commission

Signature:



Coroner Dimitra Dubrow

Date: 27 October 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
