FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 5272/08

In the Coroners Court of Victoria at Melbourne

I, **KIM M.W. PARKINSON** Coroner

having investigated the death of:

Details of deceased:

Surname: **O'MEARA**
First name: **PETER**
Address: 6 Burke Street Montmorency Victoria 3094

without holding an inquest:

find that the identity of the deceased was **PETER JOHN O'MEARA**
and death occurred on 25th November, 2008
at The Alfred Hospital 55 Commercial Road Melbourne Victoria 3004

from
1a. **INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (DRIVER)**

Pursuant to Section 67(2) of the Coroners Act 2008, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr Peter O'Meara was 59 years of age. He was a married man who resided at 6 Burke Road, Montmorency 3004. His occupation was Truck Driver.

2. Senior Constable Ashleigh Bowden of Victoria Police Port Phillip Traffic Management, provided a brief to the Coroner dated 18 August 2009, setting out police investigations and I have drawn on that material as to the factual matters in this finding.

3. Mr O'Meara had been employed as a truck driver by N&G Dunbar Tilt Tray Service Pty Ltd, for five years. He drove a company owned white Mercedes Benz tilt tray truck registered number TWO 767.

4. On 25 November 2008 he collected a container at Nepean Highway Chelsea. He was to deliver it to Dynon Road, Footscray. He collected the container at some time in the late morning.

5. At approximately 12.00pm Mr O'Meara was observed by witnesses travelling in a North East direction along City Road, South Melbourne. He was travelling towards the Light Rail Overpass in the middle lane of the three north-east bound lanes. He was apparently travelling at or below the speed limit. The light rail overpass was sign posted 3.8 metres clearance, and fitted with warning lights as to height limitations and a reinforced yellow painted safety barrier on the west side. The shipping container load was observed to be too high to pass under the 3.8 metre clearance. The shipping container was marked caution 9'6" high container, which equates with a container of 2.74 metres. That height together with the height of the truck from ground exceeded 3.8 metres clearance.

6. The shipping container struck the reinforced yellow safety barrier on the west side of the overpass. Due to the angle of the safety barrier being offset to the tray truck has caused the truck to roll onto the near side (passenger side). The near side of the shipping container collided with the northern concrete pillar of the overpass and in so doing, grabbing the pillar forcing the cabin into the pillar where it sustained extensive damage. The vehicle then came to rest under the underpass and against the northern concrete pillar. Police and Metropolitan Fire-Brigade attended the scene. Mr O'Meara sustained critical injuries and was transported by ambulance to the Alfred Hospital.

7. Witnesses who observed the truck collide with the Light Rail Bridge Yellow Safety Barrier, reported no attempt by the driver to brake. It did not appear that Mr O'Meara had been wearing a seatbelt.

8. Police investigator Sergeant Peter Bellion examined the scene and reported:

> "The tilt tray has rolled to the passenger side due to eccentric impact forces that were applied to the top of the container from the safety barriers. The container was fixed to the tray of the truck by four pins on each corner of the container. Due to the angle of the light rail overpass relative to city road, and the road crossfall to the left for drainage purposes, this has assisted the tilt tray in rolling. A preventative measure which could be considered to avoid a similar collision in the future, would be to install early warning measures for high vehicles, prior to the light rail overpass similar to the entrance at Burnley and Domain tunnels."

9. The truck was inspected by police and reported as having been in a roadworthy condition. The weather and traffic conditions were unremarkable. The overhead was signposted as to the height limit. Witnesses and police are unable to state whether the overhead warning lights were operational.

10. It is unclear why Mr O'Meara selected the City Road route to travel to Footscray. His employer stated that this was not a route he would have chosen. It is apparent that there was no attempt by Mr O'Meara to brake before the collision with the overpass, however there are no circumstances reported which would suggest that this was a deliberate act. I am satisfied that the collision more likely resulted from a lapse of attention on Mr O'Meara's part.

11. In the circumstances having considered all of the evidence available, I am satisfied that Mr Peter O'Meara died on 25 November 2009, as a result of multiple injuries sustained in a motor vehicle collision and that his death was accidental.

COMMENTS:

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

12. Site Crash Data statistics provided by VicRoads to the Coroners Prevention Unit, identify that there have been 7 incidents, heavy vehicle collision with the overhead bridge at the location between 1988 and 31 December 2009. Having regard to the number of vehicles utilising that particular roadway and underpass these may be seen to be relatively few incidents. However, Victoria Police have observed that early warning measures prior to the bridge underpass may be an effective preventative measure. I agree that it is a matter appropriate for consideration by the responsible roads authority.

RECOMMENDATION:

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

13. That consideration should be given by VicRoads to the installation of early warning signage at the approach to the light rail overpass, including the adoption of advance warning by flashing signalling as utilised elsewhere on limited height bridges.

Signature:

Coroners Court of Victoria

Kim. M.W. Parkinson
Coroner
Date: 8th February 2010