FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2350/09

Inquest into the Death of GRAEME GEORGE WATTS

Delivered On:	16th December 2010
Delivered At:	Melbourne
Hearing Dates:	15th November 2010
Findings of:	Coroner K.M.W. Parkinson
Place of death:	Intersection of Harris Gully Road and Beauty Gully Road, Warrandyte, Victoria 3113
Police Coronial Support Unit (PCSU):	Leading Senior Constable King Taylor

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Court reference: 2350/09

In the Coroners Court of Victoria at Melbourne
I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname:	WATTS
First name:	GRAEME
Address:	38 Sundowner Avenue, Clarinda, Victoria 3169

AND having held an inquest in relation to this death on 15th November 2010
at Melbourne

find that the identity of the deceased was GRAEME GEORGE WATTS

and death occurred on 8th May, 2009

at Intersection of Harris Gully Road and Beauty Gully Road, Warrandyte, Victoria 3113

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

In the following circumstances:

1. An inquest into the death of Mr Graeme George Watts was conducted on 15 November 2010. The purpose of a coronial inquiry and inquest is to establish to the extent possible the cause and circumstances causing or contributing to the death.

2. The following witnesses gave evidence in the proceeding: Mr Guy Grenfell, a witness to the incident; Senior Sergeant Robert Le Guier of Victoria Police Mechanical Investigation Unit; Senior Constable Michael McGill, Diamond Valley Traffic Management Unit, Mr Russell Davey, General Manager, Hallam Truck Centre Pty Ltd and Mr Ross McArthur, Manager Vehicle Safety and Policy, VicRoads.

3. Mr Watts was born on 2 October 1939 and he was 67 years of age at the time of his death. He resided with his wife at 38 Sundowner Avenue, Clarinda. Mr Watts was a truck driver by occupation.

4. On 11 February 2003, Mr Watts purchased a Scania brand Tipper Truck Registered RRY108 from Hallam Truck Centre of 217 Princess Highway, Hallam. The vehicle was originally manufactured as a prime mover in 1983 and had been previously registered QQI639. The vehicle had been converted from a prime mover to a tip truck at the instigation of Hallam Truck Centre. The conversion had been undertaken in December 2002 by a company H&L Enterprises (trading as H&L Truck Repairs), which has since gone out of business. The proprietor who arranged and undertook the work is permanently incapacitated and unable to make a statement or give evidence in this proceeding.

5. The evidence of Mr Russell Davey, General Manager of Hallam Trucks was that the conversion was undertaken to make the vehicle more saleable. Mr Watts was not a party to those arrangements and nor did he instigate the conversion. It appears that a Hallam Trucks staff member completed the VicRoads registration and transfer documentation, although it was also signed by Mr Watts. It is possible Mr Watts was not even aware of the modifications.

6. Whilst the vehicle was sold with a roadworthy certificate, the transfer documentation misrepresents the status of the vehicle to VicRoads. The document records and advises that the truck has not been the subject of any modification. As a result, no engineering report was submitted with the registration and transfer papers. As there are no subsequent requirements for engineering integrity testing, the opportunity to identify a problem with the structural integrity was lost as a consequence. Mr Davey stated that he did not think the work done on the truck constituted modifications required to be notified in the transfer of registration form, despite his having described the work as 'modifications'.

7. I do not accept that there is any distinction drawn by the document between types of modifications, or that there is any reasonable basis for confusion as to the obligation as described on the face of the transfer documents. The modifications to the vehicle in this case ought to have been notified and accompanied by an engineering certificate. They were not. Whether this was as a result of misunderstanding or deliberate omission is unclear on the evidence.

8. On 8 May 2009, Mr Watts was delivering loads of fill (dirt and clay) to an address at 33 Beauty Gully Road in Warrandyte. On the first delivery his vehicle was seen to overshoot the driveway by approximately two truck lengths, due to faulty brakes. The vehicle was seen to brake heavily and the brakes fail to bring it to a halt.

9. At approximately 12.20pm, Mr Watts was again driving the truck west along Beauty Gully Road (which has a downhill gradient) to effect the second delivery. The vehicle again overshot the delivery address and then continued west down the steep gradient. Police believe this was due to faulty brakes, which on these occasions entirely failed to operate. The vehicle travelled through the 'T' intersection with Harris Gully Road in Warrandyte and continued over the edge of the road, through scrub, before dropping into a creek bed and striking the creek bank. Upon impact the laden tipper body separated from the chassis, impacting the rear of the cabin. The collision trapped Mr Watts in the cabin.

10. Mr Guy Grenfell gave evidence that he was a passenger in a vehicle travelling south along Harris Gully Road. When he was approximately 500 metres from the intersection with Beauty Gully Road, he observed the truck cross the intersection at speed, in what he described as a 'flash'. He thought the truck was attempting to gain speed to run up a driveway. He then observed the truck had left the road, down a slight slope, across open ground, impacting with the embankment. Mr Grenfell and others at the scene attempted to provide assistance to Mr Watts. Police and ambulance attended, however Mr Watts was deceased at the scene.

11. At the time of the collision the weather was fine, the road was dry and in good repair, visibility was good and there was light traffic.

12. A post mortem examination was carried out by Dr Matthew Lynch, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Lynch reported that Mr Watts died as a result of multiple injuries sustained in the motor vehicle accident. He reported his findings upon autopsy as including fractures of the thoracic spine, bilateral ribs and sternum; lacerations to both lower limbs with a deep penetrating wound right popliteal fossa; avulsion of abdominal aorta from celiac axis, superior and mesenteric and renal arteries. Dr Lynch also reported significant natural disease, including cardiomegaly, myocardial fibrosis, pulmonary oedema, nephrosclerosis and brain changes suggestive of chronic systemic hypertension.

13. Victoria Police undertook a mechanical and engineering inspection of the vehicle. Senior Sergeant Le Guire reported that the vehicle was un-roadworthy immediately prior to the collision due to: maladjustment of brakes; the inadequacy of the welding modifications to the chassis; and the removal (apparently by Mr Watts)
of the driver side seat belt.

14. Senior Sergeant Le Guire stated that the brakes were seriously maladjusted with only two of six brakes being correctly adjusted. The evidence is that Mr Watts attended to the general servicing requirements of the vehicle including adjustment of the brakes. Senior Sergeant Le Guire's evidence was that the maladjusted brakes would have contributed to the collision. He stated:

"The maladjusted brakes would have reduced the vehicles ability to stop, especially during long braking applications such as descending a slope, whilst being fully laden".

15. The police inspection also revealed that the welding on the mounting of the prime mover chassis holding the tipper body on and the hydraulic ram mounting cross member had torn on impact. Further inspection of the vehicle revealed that the welding was of substandard quality. Senior Sergeant Le Guire stated:

"I also noted that the rear of both chassis rails had been modified by the top flange of the chassis rail having been straightened to be horizontal with gussets having been welded into the side member and the flange. A section of flat steel had been welded onto the inner sides of the lower flanges of the chassis, effectively boxing in the rear section of both chassis rails to provide a mount for the tipping body pivot. Both top flanges had broken the welds on both sides on impact which permitted the tipping body to move forward peeling the upper flange upwards. In addition the hydraulic ram mounting cross member had torn the welds from the tipper body mounting rails on impact..... The modification to the chassis by welding is not an industry standard and not recommended as the welding process sets up stress concentrators at the edge of the weld which lead to fracture and consequent failure. The lack of penetration in the welding of the modifications would have contributed to the tipping body breaking free of the vehicle and crushing the cabin which would have contributed to the deceased's injuries."

16. I am satisfied that the brakes on the vehicle had been improperly adjusted and were faulty. The absence of adequate braking capacity resulted in Mr Watts being unable to control the vehicle and the vehicle leaving the roadway and colliding with the embankment. The collision was a major impact collision, where the cabin was impacted by both the embankment at front and by the tipper from the rear.

17. I am satisfied that the structural alterations to the vehicle, in particular the welding work on the chassis by H&L Enterprises was substandard and when subject to load, unable to withstand force, in particular that of impact. I accept Senior Sergeant Le Guire's evidence that the crushing of the cabin by the intrusion of the tipper consequent upon the welding failure, contributed to Mr Watts injuries.

18. I am satisfied that the crushing of the cabin by the tipper body, in addition to the impact with the embankment contributed to Mr Watts death. I find that the substandard welding work in the structural alterations to the heavy vehicle also contributed to his death. I find that the failure by Mr Watts to maintain the brakes on the vehicle in a roadworthy condition also contributed to his death.

19. Having regard to the injuries sustained as a result of crushing and impact, largely from the tipper, it is likely that the absence of a seat belt was not the most significant contributing factor to the death, however it cannot be excluded as a factor in the death.

20. I find that Mr Graeme Watts died on 8 May 2009 at Warrandyte and that he died as a result of injuries sustained in a motor vehicle collision as a driver.

COMMENT:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

Engineering supervision of the integrity of heavy vehicle modifications

1. Once a heavy vehicle has been modified, the modifications are required to be certified by an authorised engineer prior to any transfer of registration taking place. This is to ensure the quality and the integrity of the work and the safety of the new owner. In the absence of an engineering certification no transfer should take place. In this case, because the information as to modification provided by the dealer to VicRoads was incorrect, there was no immediate indicator to VicRoads to check the engineering status of the vehicle.

2. The result was that no assessment by any authoritative expert had been undertaken of the integrity of the welding works, which had been used to convert the vehicle from a prime mover to a tipper truck. Consequently, the registration of the motor vehicle was transferred to Mr Watts. It is likely that Mr Watts had no knowledge of the inadequacy of the welding on the modifications and may not have been aware that the vehicle had previously been a prime mover.

3. There does not appear to be any legislative or regulatory obligation upon a seller of a modified heavy vehicle to notify the purchaser of the modification prior to purchase. The availability of this information to a purchaser would enable them to make informed decisions as to the safety of the motor vehicle they are purchasing and driving.

4. Mr McArthur of VicRoads accepts that it was apparent on the documentation that the vehicle had previously been registered and that cross checking by VicRoads officers would have revealed that the vehicle had in fact been substantially modified, from a prime mover to a tip truck. In view of the transfer being effected without engineering certification, it appears that this cross checking did not occur. Mr McArthur informed the court that procedures now require that a matching of both sets of registration documentation occur before transfer will be effected. This offers an additional measure of supervision of the veracity of information provided.

RECOMMENDATIONS:

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

1. VicRoads have implemented measures to cross check previous registrations without solely relying upon the accuracy of the information provided in the transfer documents. This will enable VicRoads to identify that a vehicle has been modified and thus requires an engineering certificate. Having regard to these measures I make no recommendations in this regard.

2. There is no legislative requirement at point of sale to notify a purchaser of a second hand heavy vehicle, that the vehicle has been modified from its original engineering and design. I recommend that the responsible minister give consideration to legislation or regulation to require such notification.

3. I direct that a copy of these findings be provided to the Minister for Police; Minister for Roads; VicRoads; WorkSafe Victoria; the Victorian Automobile Chamber of Commerce; and the interested parties.

Signature:

K.M.W. Parkinson
Coroner
16th December 2010