FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3877/09

Inquest into the Death of SIMON PETER GARDNER

Delivered On:	15th March 2011
Delivered At:	Coroners Court, Melbourne
Hearing Dates:	15th March 2011
Findings of:	CORONER, JOHN OLLE
Place of death:	62 Tweddle Road, Gisborne South, Victoria 3437
PCSU:	Leading Senior Constable King Taylor

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3877/09

In the Coroners Court of Victoria at Melbourne

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: GARDNER
First name: SIMON
Address: 62 Tweddle Road, Gisborne South, Victoria 3437

AND having held an inquest in relation to this death on 15th March 2011 at Melbourne

find that the identity of the deceased was SIMON PETER GARDNER and death occurred on 8th August, 2009

at 62 Tweddle Road, Gisborne South, Victoria 3437

from
1a. CHEST INJURIES
1b. MOTORCYCLE INCIDENT (RIDER)

In the following circumstances:

1. Simon Gardner was aged 14 years at the time of his death. He lived at 89 Aitken Street, Gisborne.

2. The coronial brief has fully and accurately addressed the circumstances of Simon's death.

Incident Circumstances

3. Simon was an experienced motorcycle rider, having ridden dirt bikes from the age of 5 years. He sustained fatal injuries when the 150cc motorcycle he was riding collided with an unregistered Datsun 'paddock bomb', driven by a 13 year old girl on private semi-rural property in Gisborne, Victoria. The property was owned by the girl's father ('the owner') and was not used for commercial purposes.

4. The vehicles were travelling in the same direction in a circular motion. Shortly prior to impact, the vehicles commenced travelling in opposite directions. There was insufficient time to avoid impact.

5. Simon was considered to be a very experienced motorcycle rider, having commenced riding dirt bikes from 5 years of age.

Factors contributing to collision

6. The coronial investigator identified the following factors:

- The young ages of the persons involved;
- The lack of driving experience of the driver of the 'paddock bomb';
- Misunderstanding of the hand signals and verbal directions given by Simon to the car driver;
- The speed at which Simon was travelling;
- The lack of rules or verbal instructions as to the direction the vehicles should have been travelling, and responses in an emergency situation.

7. In addition, the lack of parental visual supervision was noted.

8. The owner had implemented rules for operating vehicles on his property. I accept he genuinely believed the rules were appropriate to render the activity safe. Earlier on the day of the collision, he intervened and reminded the children not to speed.

9. In my view, wisdom discovered after the tragic event identified the potential for tragedy.

Coronial function is prevention, not blame

10. Simon's family have suffered an unimaginable loss. His friends, in particular those present on the day of his death have suffered greatly. It would be futile and unfair to criticise any individual for the circumstances leading to Simon's death.

A catalyst for change

11. The circumstances of Simon's death may provide a catalyst for change. I now turn to prevention.

Coroner's Prevention Unit (CPU)[1]

12. At my request, the CPU has undertaken extensive research to examine the nature and extent of injuries sustained by young persons involving motorcycles in off-road settings. I take this opportunity to note the invaluable assistance the CPU has provided my investigation.

CPU Research Findings

Context

13. CPU investigations revealed that the popularity of off-road motorcycle riding has increased considerably in recent years both in Victoria and nationally. By way of example, sales of off-road motorcycles have surged with a reported 50% increase between 2004 and 2008 alone. In 2009, there were 42,848 off-road bikes sold nationally, compared to 42,372 road bikes and 10,398 scooters.[2]

14. Off-road motorcycle riding is a diverse recreational and sporting activity. While there is no consistent definition of 'off-road' it is generally implied to be any riding location other than a public road. There are numerous riding clubs and associations throughout Victoria although only a small proportion of riders tend to be members, with most partaking in informal riding arrangements with friends or family.

15. Riders need to be at least 18 years of age to hold a motorcycle learner permit and ride on Victoria's public road network hence riders less than 18 years of age must resort to riding on private property.

16. It has been identified by numerous agencies, most recently by the Victorian Auditor-General's Office, that off-road motorcycling in Victoria results in a significant number of injuries each year. While road safety efforts have addressed on-road motorcycling, little action has been taken to date to address off-road motorcycling safety. A lack of a lead government agency to facilitate efforts has been recognised as a key issue.

Frequency and nature of off-road motorcycling injury

17. There was evidence from a range of sources that off-road motorcycling injuries are frequent in Victoria and their numbers have been increasing over time across all age groups. A summary of the key findings is outlined below.

[1] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.
[2] See the Federal Chamber of Automotive Industries website, Solid result for motorcycle sales in 2009. Retrieved from: http://www.fcai.com.au/news/all/all/235/solid-result-for-motorcycle-sales-in-2009

18. Between 1 January 2000 and 31 December 2010, 68 off-road motorcyclist deaths (two-wheeled only) reported to the Victorian Coroner were identified by the CPU. Of these riders, 15 (22%) were under 18 years of age.

19. The Victorian Injury Surveillance Unit (VISU), found that in a three year period (2002/03 to 2004/05) there were 3,444 hospital admissions and 3,564 emergency department (ED) presentations for off-road motorcycling injuries in Victoria. Children aged 0-17 years accounted for 30% of all admissions and a third of ED presentations. Moreover, almost half of all motorcycling hospital admissions were due to off-road riding.[3]

20. A Royal Children's Hospital study found that off-road motorcycling injuries accounted for 90% (2,832) of all motorcycle-related ED presentations among children aged 16 years and under in Victoria between July 2000 and June 2004. Over 80% (2,665) of those injured were males, and half were aged between 10 and 14 years (1,523). Injuries requiring ED treatment increased by almost 10% each year during the study period.[4]

21. A recent study by the Alfred Hospital on off-road motorcycle-related major trauma and deaths of persons aged 16 years and over, found an increased incidence of injury (0.8 to 1.4 cases per 100,000 population) from July 2001-June 2008.[5]

22. Concerns have also been raised interstate. A New South Wales study found that motorcyclists accounted for 40% (n=15,004) of all non-traffic[6] injury hospitalisations, with hospitalisation rates increasing by over 3% each year from 1998 to 2007.[7]

Safety concerns

23. There have been numerous calls in Victoria in recent years for action to be taken to address the growing incidence of motorcycling injuries, among young children in particular.

24. The Royal Children's Hospital study concluded that:

> *"there is an urgent need for coordinated legislative changes and educational efforts to decrease motorcycle injuries in children."*

---

3 Victorian Injury Surveillance Unit (2006). On and Off-road Motorcycling Injury in Victoria. Hazard report no. 64.
4 Bevan, C.A., Babl, F.E., Bolt, P. & Sharwood, L.N. (2008). The increasing problem of motorcycle injuries in children and adolescents. Medical Journal of Australia. 189(1), p.17-20.
5 Mikocka-Walus, A., Gabbe, B. & Cameron, P. (2010). Motorcycle-related major trauma: on-road versus off-road incidence and profile of cases. Emergency Medicine Australasia. 22(5), p.470-476.
6 Non-traffic refers to injuries occurring in transport incidents not occurring on a public highway [roads and road-related areas].
7 Chong, S., Du, W. & Hatfield, J. Trends in the incidence of hospitalisation for injuries resulting from non-traffic crashes in New South Wales, July 1998 to June 2007. Medical Journal of Australia. 193(4), p.223-226.

25. VISU called for similar action, including a recommendation for the:

> *"appointment by the Victorian government of one government department/agency to take the lead and co-ordination role for off-road motorcycling safety and establishment of a consultative body to advise on state-wide and local injury prevention and control measures."*

26. Yet despite these calls, it is evident that off-road motorcycling safety has received little, if any attention to date. In February 2011, the Victorian Auditor-General's Office released a report examining the success of road safety agencies in improving motorcycle and scooter rider and passenger safety, both on and off the public road system. The report stated:[8]

> *"Road safety agencies have not adequately addressed the safety of riders travelling anywhere other than public roads. This needs to change because we found that off-road injuries are responsible for half of all the hospital admissions resulting from motorcycle crashes."*
> *Further;*
> *"While VicRoads, VicPol, [Victoria Police] and the TAC have targeted initiatives to address most of the identified safety risks for riders travelling on public roads, improving the safety of off-road riders has lagged behind. This significant gap requires attention."*

27. The Victorian Auditor General's report outlined what actions had been done since 2002 to address off-road rider safety.[9] This summary is notable for identifying the total absence of any strategy, policy or plan to address off-road rider safety in Victoria. A Trail Bike Project was initiated and led by the Department of Sustainability and Environment and involved contributions from the Victorian Motorcycling Advisory Council (VMAC). This project was developed to address the environmental impact of trail bike riding and the potential conflicts with other park users; issues involving rider safety were not specifically addressed.

Past coronial recommendations on this issue

28. The CPU examined previous comments and recommendations made by Coroners in Victoria and interstate.

29. Following a coronial inquest concerning the death of a three year old boy, Victorian Coroner Andrew Capell, recommended in June 2009 that consideration be given to the introduction of regulation to ensure children of a certain age cannot ride a motorcycle off-road until a minimum level of competency or hazard appreciation has been achieved.[10]

---

[8] Victorian Auditor-General's Report - Motorcycle and Scooter Safety Programs. February 2011.
[9] See page 25 of the Victorian Auditor General's report.
[10] See finding into the death of Cody Williams, Victorian case no. 3573/2007.

30. In response to the death of a 21 year old trail bike rider, Tasmanian Coroner Olivia McTaggart, recommended in June 2010 that the Tasmania Government take a lead role in conjunction with stakeholders in organising and conducting regular training sessions for off-road motorcyclists. Coroner McTaggart further urged all persons involved in the sport to wear approved safety apparel at all times to reduce the risk of death and injury.[11] Coroner McTaggart also noted that it:

> *"appears often that there is a lack of appreciation of the risks involved in the sport by inexperienced riders, or their parents, who may purchase motorcycles for them." Further,*
> *"..basic education of riders and their parents is important and likely instrumental in saving lives and preventing injury."*

31. Tasmanian Coroner Shan Tennent, investigated the death of a 14 year old male in 2001 who died when his trail bike collided head on with another rider whilst riding on trails created on Crown land.[12] The two riders were travelling in opposite directions, contrary to the 'unwritten riding code' and collided at a crest on the track.

32. In her finding handed down in April 2009, Coroner Tennent stated:

> *"Comment must in my view be made about the dangers inherent in the boys' trail bike riding in the circumstances in which they were. The trails being used were not clearly marked and safety arrangements were dependent on an unwritten sort of code amongst the young people who frequented the tracks being known to anyone who might ride there. There were otherwise no controls at all and no level of supervision by any person or body to ensure such rules as there were adhered to. Both boys in this case were, on the evidence, experienced, their bikes were in good condition, they were wearing protective clothing and they knew the rules. Yet still one of them has died. The activities in this area should have been policed or stopped."*

Prevention Measures

33. The CPU contacted a diverse range of organisations to assist my investigation, including:

- The Victorian Injury Surveillance Unit, Monash University Accident Research Centre
- Royal Children's Hospital Child Safety Centre;
- FarmSafe Victoria;
- KidSafe Victoria;

[11] See finding into the death of Christopher Smith, Tasmanian case.
[12] See finding into the death of Joshua Ferrar, Tasmanian case.

- Office of the Child Safety Commissioner;
- Department of Health;
- VicRoads;
- Sport and Recreation Victoria;
- Motorcycling Victoria.

34. I acknowledge with gratitude the co-operation offered to CPU by all agencies consulted.

35. The following initiatives addressing off-road motorcycling safety for children in Victoria were identified:

- FarmSafe Victoria's ongoing engagement with farming and rural communities;
- The Royal Children's Hospital Child Safety Centre's Child Safety Handbook comprising information on motorcycling safety on farms; and
- Motorcycling Victoria's MotorSafe education program for primary school-aged students.

36. Discussions held by CPU with safety agencies indicated that the wider community may in fact not be aware of the extent and severity of motorcycling injuries suffered by children and adolescents. Agencies felt that parents and carers should be in a position to make informed decisions on their child's use of motorcycles and be aware of the various ways to minimise injury risk.

37. It was suggested that safety messages would need to emphasise things such as:

- The importance of selecting a motorcycle of an appropriate size and engine capacity for the rider, and maintaining the vehicle;
- Provision of a controlled riding environment suited to the rider's level of competence, with minimal objects such as trees or fences and concurrent vehicles in operation;
- Wearing of protective and conspicuous clothing and equipment including helmets, gloves and sturdy footwear;
- Parent or carer supervision during riding activities; and
- Parents acting as role models and displaying appropriate riding behaviour (i.e. wearing of helmets).

38. The many barriers and difficulties associated with establishing a minimum age at which a child may ride a motorcycle was also raised. As the riding of a motorcycle on private land is not regulated, the question of age restrictions is not relevant at this time. Other prevention measures proposed included:

- Education and awareness campaigns targeting riders and parents/carers;
- Expansion of the provision of supervised and purpose-built off-road riding venues;
- Encouragement and enforcement of the use of helmets and protective clothing; and
- The development, standardisation and evaluation of skills and risk awareness training courses, and internet-based packages.

Responsible agencies

39. It became evident during the course of my investigations that a major impediment to responding to off-road motorcycling injuries has been the lack of a lead agency to coordinate efforts. Off-road motorcycling safety clearly spans the jurisdiction of several state government agencies.

40. The Victorian Auditor-General's report noted that each of the Victorian road safety agencies (VicRoads, Victoria Police and the Transport Accident Commission) have a role in off-road motorcycling safety. I also note that on the VicRoads website, the VMAC:

> *"has a strong interest in addressing off-road motorcycling issues."*

41. In 2010 the Department of Health advised the CPU that a new Victorian Injury Prevention Strategy will be developed and implemented by the second half of 2011. The Department of Health advises that the key outcome of the proposed Strategy would be a:

> *"new, evidence-informed strategy to guide existing work and future directions in injury prevention across Victoria."*

42. While off-road motorcycling safety can be addressed by road safety agencies, there is both a clear role and opportunity for the Department of Health to collaborate.

Post Mortem Medical Investigation

43. On the 12th August 2009, Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Simon Gardner.

44. Dr Iles found the cause of death to be chest injuries and motor cycle incident (rider).

Finding

1. I find the cause of death of Simon Gardner to be chest injuries and motor cycle incident (rider).

COMMENTS:

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):

1. Injuries from off-road motorcycling will undoubtedly continue to rise in line with its increasing popularity unless immediate action is taken. I acknowledge that off-road motorcycling is a diverse activity. Safety concerns will range for example from young persons riding on private land with parents and friends, recreational and competition riding at official venues, and trail bike riding on public land.

2. The release of the Victorian Auditor-General's report was timely for the purposes of this investigation. It demonstrated not only that off-road motorcycling safety is a broad and complex issue, but that numerous government agencies each have a role to play in collectively addressing the various safety risks.

3. The death of Simon Peter Gardner is a tragedy. The legacy of his death offers the opportunity to implement sweeping change in off road motor cycling safety.

RECOMMENDATIONS:

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

I therefore consider the following recommendations appropriate:

1. That the Department of Health implement a Victorian Injury Prevention Strategy and place off-road motorcycling safety as a key priority under this Strategy.

2. That as part of the Victorian Injury Prevention Strategy, the Department of Health facilitate a targeted awareness campaign to address the safety of children riding motorcycles informally with friends and family.

3. That VicRoads establish a sub-committee of the Victorian Motorcycling Advisory Council whose prime responsibility should be examining off-road motorcycling in order to develop evidence-based strategies to reduce the number of injuries. The committee members should extend beyond road safety groups to include appropriate bodies such as the Department of Sustainability and Environment, the Department of Health and off-road riding associations.

Signature:

John Olle
Coroner
15th March, 2011