



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2018 5660

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

**Findings of:**

**AUDREY JAMIESON, CORONER**

**Deceased:**

**GRAHAM WILLIAM SUMMERFIELD**

**Date of birth:**

**13 September 1936**

**Date of death:**

**9 November 2018**

**Cause of death:**

**Complications of multiple injuries (palliated),  
sustained in a quad bike incident**

**Place of death:**

**West Gippsland Hospital, 41 Landsborough Street,  
Warragul Victoria 3820**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Graham William Summerfield was an 82-year-old man who lived with his wife, Paula Summerfield, at 421 Bullswamp Road, Bona Vista Victoria 3820.
2. On 6 November 2018, Mr Summerfield was involved in an unwitnessed quad bike incident along Bullswamp Road. He sustained serious injuries and was taken to Alfred Hospital Emergency Department.
3. On 8 November 2018, Mr Summerfield was transferred to West Gippsland Hospital for palliative care.
4. On 9 November 2018, Mr Summerfield died as a result of his injuries.
5. Mr Summerfield's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural and to have resulted, directly or indirectly, from an accident.

## INVESTIGATIONS

### *Forensic pathology investigation*

6. Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mr Summerfield, reviewed a post mortem computed tomography (CT) scan, Warragul Hospital e-Medical Deposition Form and referred to the Victoria Police Report of Death, Form 83.
7. Dr Young commented that the external examination showed bruises and abrasions on Mr Summerfield's face, neck, forearms and knees. Some bruising was seen under the tongue. No *unexpected* signs of trauma were identified.
8. The post mortem CT scan confirmed the presence of subdural haemorrhage, as well as malalignment of the cervical spine, and haemorrhage in the right maxillary sinus. Mr Summerfield's heart showed coronary artery calcification. No other *significant* pathology was identified.
9. Dr Young further commented that complications of injuries such as those seen in Mr Summerfield include pneumonia (chest infection), increased stress on the heart

(especially in the context of known ischaemic heart disease), multi organ system failure, and development of deep vein thrombosis and pulmonary thromboembolism.

10. Dr Young ascribed the cause of death as complications of multiple injuries (palliated), sustained in a quad bike incident.

#### *Police investigation*

11. Upon attending the scene of the incident along Bullswamp Road, after Mr Summerfield was conveyed to hospital, Victoria Police investigating officers examined the scene. Upon Mr Summerfield's death several days later, a coronial investigation was commenced.
12. Leading Senior Constable (LSC) Carlo Visser was the nominated Coroner's Investigator.<sup>1</sup> At my direction, LSC Visser investigated the circumstances surrounding Mr Summerfield's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, witnesses, treating clinicians and investigating officers.
13. During the investigation, police learned that Mr Summerfield was a dairy farmer who milked 46 cows morning and night on his property on Bullswamp Road. Mr Summerfield had lived at the farm his entire life and was very familiar with the area.
14. Mr Summerfield had a history of motor vehicle incidents, including an incident in 2009 where he "T-boned" another vehicle and an incident in 2016, where he fell asleep at the wheel and sustained mandibular fracture and rib fractures.
15. The 2016 incident occurred along Bullswamp Road at Bear Creek, approximately 100 metres from the site of his fatal incident. Mr Summerfield required extensive rehabilitation over several weeks. Family statements detail that the incident "slowed" Mr Summerfield and affected his mobility. As a result, he was only able to ride his quad bike "side saddle". "He was unable to get his leg over the saddle to ride properly."

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<sup>1</sup> A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

16. Following the incident, Mr Summerfield was required to undergo a review of his Victorian Driver's Licence. Upon failing the eye test at VicRoads, Mr Summerfield's Victoria Driver's Licence was not renewed. The expiration date of his previous licence was 20 September 2017. Additionally, records indicate that Mr Summerfield had never held a motorcycle licence.
17. Despite having lost his Victorian Driver's Licence, Mr Summerfield was known to ride his unregistered Honda quad bike out onto the surrounding roads of his residence to visit friends in the local area and to go about his business. Mr Summerfield's son, Ross Summerfield, states that "I would either see him or hear the bike coming and he would be riding side saddle either [sic] in the wrong gear, as you could hear the bike either revving loudly or labouring until he got going."
18. Mr Summerfield purchased the Honda quad bike approximately five years prior to his death second hand. Mr R. Summerfield, details that his father "rode motorbikes and quad bikes around the farm for about 30 – 40 years and was experienced on them".
19. On 6 November 2018 prior to 7.00pm, Mr Summerfield rode his quad bike west along Bullswamp Road between property 462 and Bear Creek. Due to an unknown reason, Mr Summerfield lost control of the quad bike and was thrown from the vehicle.
20. At approximately 7.00pm, Patricia Blair was driving west along Bullswamp Road, when she saw "a large branch" on the roadway. "It was three parts across the left lane..." Ms Blair swerved to the right to avoid colliding with the branch. As she did so, Ms Blair noticed Mr Summerfield lying on the grassed edge of the road. Ms Blair noted Mr Summerfield was not wearing a helmet and was bleeding from his head. She immediately called emergency services.
21. Ambulance paramedics and Victoria Police arrived shortly after. Investigating officers observed Mr Summerfield lying on the northern side of Bullswamp Road. He was unable to move and had visible head injuries, to which paramedics attended.
22. Approximately six metres down the embankment, investigating officers observed a red Honda quad bike resting against a tree. No other vehicles were observed in attendance.

23. Mr Summerfield was conveyed to Alfred Hospital, arriving at approximately 9.30pm to a full Trauma reception. Upon examination, Mr Summerfield was considered to have sustained significant trauma from the incident, including quadriplegia.
24. On 7 November 2018, Mr Summerfield's prognosis was reviewed and the decision to palliate was made. He was kept in the Intensive Care Unit (ICU) overnight with input from the Trauma Service, ICU, Orthopaedics, Facial Maxillary, Palliative Care and Social Work.
25. On 8 November 2018, Mr Summerfield was transferred to West Gippsland Hospital for "End of life Care".
26. On 9 November 2018 at approximately 4.44pm, Mr Summerfield died from his injuries.
27. Victoria Police immediately commenced a coronial investigation.
28. An assessment of the incident site revealed that Bullswamp Road is a two-way road with no line markings separating traffic. The speed limit is 100 kilometres an hour. The site of the incident is straight and approximately six metres wide. It is a bitumen surfaced road with gravel shoulders. White coloured marker posts are positioned on the shoulder of the road. There is a downhill slope towards Bear Creek.
29. On the evening of the incident, the gravel was covered with "leaf litter".
30. Visibility on the evening of the incident was clear.
31. An examination of the scene showed that there were no skid or yaw marks on the bitumen road's surface. Investigating officers noted a skid mark in the "leaf litter" on the northern side of the road's shoulder. This mark, in addition to another mark that was observed two metres from the road surface, indicated that Mr Summerfield's quad bike had overturned, rolled back onto its wheels and then come to a rest against a tree.
32. On the southern side of the road, investigating officers noted several branches and small gum tree limbs lying on the ground. The branch that Ms Blair referred to in her statement had already been moved from the roadway. Investigating officers were unable to ascertain who moved the branch.

33. The unregistered quad bike was considered to be in poor overall condition. Specifically, it was missing a rubber handgrip on the left hand side, it had ineffective tail lights and no roll over protection. The tyres were of an off road pattern and the tread was minimal. In addition, Mr Summerfield was not wearing a helmet at the time of the incident.
34. Investigations revealed that Mr Summerfield regularly rode his quad bike down Bullswamp Road and that he often road down the centre of the road at approximately 15 kilometres an hour. Statements indicated that Mr Summerfield was not the most cautious of drivers, often lacking concentration on the road ahead. “He was like a Sunday driver”.
35. Investigating officers concluded that on 6 November 2018, Mr Summerfield was travelling west along Bullswamp Road when he attempted to swerve around a branch that was on the road’s surface. As he did so, Mr Summerfield was thrown from the quad bike and landed heavily on the road, otherwise known as being “highsided”. The quad bike has possibly rolled over Mr Summerfield, before rolling approximately six metres and coming to a rest against a tree.

## COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I directed the Coroners Prevention Unit (CPU)<sup>2</sup> to identify the frequency of deaths involving quad bikes in recent years. The CPU identified 33 deaths involving quad bikes that occurred in Victoria between 1 January 2010 and 31 August 2020. Four of these deaths occurred in 2020; an increase from two deaths in 2019 and one death in 2018.
2. Over the period of analysis, the majority of deceased (90.9%) were male, and the highest frequency of deaths occurred in those aged 65 years and over (48.5%), followed by those aged 10 to 14 years and 35 to 44 years (each 12.1%). Of the deaths where the coronial investigation has concluded, the evidence suggests that 15 deceased were not

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<sup>2</sup> The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the VIFM medical investigation report and any particular concerns which have been raised.

wearing a helmet at the time of the incident. This analysis shows that deaths involving quad bikes remains an ongoing public health and safety issue in Victoria.

3. Victorian coroners have long been engaged in efforts to reduce quad bike fatalities. Namely, there have been several recommendations over the years to various government bodies suggesting that the control of sale, distribution and use of quad bikes would likely serve as a preventative mechanism in quad bike fatalities.
4. I note that Mr Summerfield is alleged to have purchased his quad bike second hand some five years prior to his death. I appreciate that the control of on-sale in such situations would be difficult for authorities to monitor, especially in circumstances where the vehicle is not registered.
5. Nonetheless, having reviewed the evidence available to me, I consider Mr Summerfield's death to have been a preventable death. Quad bike riding is by nature, a high-risk activity. I note Mr Summerfield did not hold a valid Victorian Driver's Licence and was not wearing appropriate protective gear at the time of his incident. I further note that his quad bike was not registered, nor was it in good working condition.
6. Mr Summerfield failed to meet the requirements of his Victorian Driver's Licence renewal, including passing the eyesight test. He was known to lack concentration when driving and he was also only able to ride his quad bike "side saddle" and not fully straddled over the seat allowing for appropriate control of the vehicle.
7. Despite failing the conditions of his licence renewal, I am satisfied that had Mr Summerfield been wearing appropriate protective gear, had he been seated properly on the quad bike and had his quad bike been in good working condition, the outcome of his incident on 6 November 2018 would have likely been different.
8. For this reason, I have included the Minister for Roads and Road Safety, WorkSafe Victoria and Consumer Affairs Victoria in the distribution list of this Finding for consideration as to how deaths such as Mr Summerfield's may be prevented in the future.

## FINDINGS

1. I find that Graham William Summerfield, born 13 September 1936, died on 9 November 2018 at West Gippsland Hospital, 41 Landsborough Street, Warragul Victoria 3820.
2. I accept and adopt the cause of death ascribed by Dr Gregory Young and I find that the cause of Mr Summerfield's death was complications of multiple injuries (palliated), sustained in a quad bike incident in circumstances where I find that his high-risk behaviour contributed to his death.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Paula Summerfield, senior next of kin

Glenda Cutler, daughter

The Hon. Ben Carroll, Minister for Roads and Road Safety

Alexis Hurwitz, WorkSafe Victoria

The Proper Officer, Consumer Affairs Victoria

Leading Senior Constable Carlo Visser

Signature:



AUDREY JAMIESON

CORONER

Date: **28 September 2020**

