IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2020 003507**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Audrey Jamieson
Deceased:	Kelvin Maurice Jeffery
Date of birth:	26 December 1923
Date of death:	01 July 2020
Cause of death:	1(a) Blunt chest trauma from quad bike accident
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052

INTRODUCTION

1. On 01 July 2020, Kelvin Maurice Jeffery was 96 years old when he died at The Royal Melbourne Hospital from injuries sustained in a quad bike accident. At the time of his death, Mr Jeffery lived alone on his rural property at Canary Island, Victoria.

THE CORONIAL INVESTIGATION

2. Mr Jeffery'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Jeffery's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Kelvin Maurice Jeffery including evidence contained in the coronial brief. 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]

[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.

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

Circumstances in which the death occurred

7. Mr Jeffery has been described as a proud, independent and competent man. Specifically, that despite his age, he was self-sufficient and took care of both himself and his property until the time of his death.[2]

8. On 26 June 2020, Mr Jeffery spoke with his grandson, Craig Campbell, regarding assistance moving cattle on his property. The paddock that he wished to move cattle from was approximately five kilometres from his house.[3] Statements detail that Mr Jeffery was set to sell 15 of his cattle and that they were relatively large in size, requiring more than one person to move. Family members were unable to assist on this day.[4] It was decided that the cattle would be moved on Sunday, 28 June 2020, with Mr Campbell's assistance.

9. On 27 June 2020, Mr Jeffery contacted Mr Campbell and his friend, Mr Barnes and advised that he would move the cattle on his own. Mr Campbell told his grandfather that the cattle would be moved on the Sunday, when he and Mr Barnes were there to assist.[5]

10. At approximately 12.45pm, Vincent Bartels travelled to Mr Jeffery's house. As Mr Bartels travelled down Yando Canary Island Road, he slowed his vehicle when he noticed approximately 12 cattle on the road ahead. Mr Bartels also noticed a quadbike off to the right side of the road and a person laying on the ground.[6]

11. Mr Bartels got out of his vehicle and ran down to the person lying in the grass. As he did so, he realised the person in the grass was Mr Jeffery. Mr Jeffery was conscious and attempting to lift his head. Mr Bartels called emergency services and kept Mr Jeffery lying down until Ambulance Victoria[7] arrived at approximately 1.20pm.[8]

12. On examination, Mr Jeffery was conscious, breathing and appeared orientated. It was noted that Mr Jeffery appeared to not have been wearing a helmet at the time of his collision.[9] He had a deep laceration of approximately 8 centimetres with hematoma on the right side of his

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[2] Statement of Kaye Campbell dated 29 August 2020.
[3] Statement of Kaye Campbell dated 29 August 2020 and Statement of Charles Barnes dated 16 August 2020.
[4] Statement of Kaye Campbell dated 29 August 2020.
[5] Statement of Charles Barnes dated 16 August 2020.
[6] Statement of Vincent Bartels dated 26 August 2020.
[7] Ibid.
[8] Statement of Fiona Cockerell (Ambulance Victoria) dated 18 September 2020.
[9] Statement of Joshua James King (Ambulance Victoria) dated 15 October 2020.

forehead. The "*little finger*" on his left hand had been amputated at the knuckle.[10] Mr Jeffery complained of pain to his right-side ribs and thoracic area of his back. Decreased breath sounds in his right-side chest were noted.[11]

13. At approximately 2.53pm, Mr Jeffery was transported by air ambulance to The Royal Melbourne Hospital.[12] He arrived at 8.00pm and was admitted to the Intensive Care Unit. Tests revealed a diagnosis of right sided haemopneumothorax, 9 right sided rib fractures, comminuted fracture to right pelvis with associated haematoma and intraperitoneal haemorrhage, right scalp laceration and complete amputation of right fifth finger.[13]

14. Mr Jeffery developed type 2 respiratory failure and was deemed not for surgical intervention. The decision was made to palliate.[14]

15. On 1 July 2020 at 10.55pm, Mr Jeffery succumbed to his injuries and was declared deceased.[15]

Identity of the deceased

16. On 1 July 2020, Kelvin Maurice Jeffery, born 26 December 1923, was visually identified by his daughter, Kaye Campbell.

17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 3 July 2020 and provided a written report of his findings dated 6 July 2020.

19. The post-mortem examination showed findings in keeping with the clinical history. Examination of the post-mortem CT scan showed no head or neck fractures or intracranial haemorrhage. Multiple right lateral rib fractures, 8-10 latero-posterior left rib fractures, sternal wires, aortic valve replacement, and aorta-iliac AAA repair graft. Right pelvic fractures were also noted and probable haemothoraces but no evident pneumothorax. Dr Beer further noted

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[10] Statement of Fiona Cockerell (Ambulance Victoria) dated 18 September 2020.
[11] Statement of Joshua James King (Ambulance Victoria) dated 15 October 2020.
[12] Statement of Fiona Cockerell (Ambulance Victoria) dated 18 September 2020.
[13] E-Medical Deposition Form, Case Reference Number: 2020003507
[14] Statement of Charles Barnes dated 16 August 2020.
[15] E-Medical Deposition Form, Case Reference Number: 2020003507

cardiomegaly with coronary artery calcification and coronary artery bypass grafts and increased lung markings.

20. Toxicological analysis of post and ante-mortem samples identified the presence of drugs normally detectable at therapeutic concentrations.

21. Dr Beer provided an opinion that the medical cause of death was 1 (a) blunt chest trauma from quad bike accident.

FURTHER INVESTIGATIONS

22. It was detailed that Mr Jeffery would usually move his cattle by riding one of his two quad bikes. One quad bike had a roll bar and the other did not. Mr Jeffery was "*hunched*" and had taken to riding the quad bike without the roll bar because his visibility was better. Previous incidents riding the quad bike with the roll bar had seen Mr Jeffery almost tip backwards due to poor visibility and getting caught on branches.[16]

23. At approximately 1.32pm, Victoria Police attended the scene prior to Mr Jeffery being transported to The Royal Melbourne Hospital. Leading Senior Constable (**LSC**) Lynette Jenkins stated that Mr Jeffery had been riding his quad bike when he had lost control, causing the vehicle to run into a fence post before tipping over onto its side. Due to the accident occurring on private land, LSC Jenkins notified WorkSafe Victoria.[17]

24. At approximately 5.10pm, WorkSafe Victoria investigator, Mark Hamilton, attended the sight of Mr Jeffery's collision. Mr Hamilton noted the area to be rural, with paddocks on both sides of a dirt road. He further noted a timber fence that Mr Jeffery was located near.[18]

25. Mr Hamilton attended Mr Jeffery's residential address, where he was shown the Kawasaki 300 cc 4-wheel ATV without "*roll protection*" that was involved in Mr Jeffery's collision. Mr Hamilton noted that the accelerator had been altered to operate via a retrofitted homemade timber accelerator pedal consisting of a piece of timber and an old hinge. No additional investigations were undertaken by WorkSafe Victoria[19]

26. The adjustments to the accelerator were supported in Mr Barnes' statement. He detailed that as he was a qualified retired mechanic, to assist Mr Jeffery in operating the vehicle, he "*placed*

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[16] Statement of Kaye Campbell dated 29 August 2020.
[17] Statement of Leading Senior Constable Lynette Jenkins dated 4 November 2020.
[18] Statement of Mark Hamilton (WorkSafe Victoria) dated 5 November 2020.
[19] Ibid.

the throttle from the handlebar down onto a bracket on the right-hand step". This was considered the safest option, given that Mr Jeffery would use the vehicle in any event, as it was his only means of transport around his property.[20]

27. Various statements detailed several health issues relating to Mr Jeffery's eyesight, his hunched back and his hands seizing up. All of which would have affected his ability to ride his quad bike and potentially contributed to his accident.[21]

28. It was noted in several statements that Mr Jeffery wore his "*live life alarm*" medical alert the day of his accident. The alert was set-up to alert five family members in the event of a fall or an accident. Alerts were automatic or could be triggered by Mr Jeffery by pushing a button. In recent times, the alarm had become faulty and was recently sent away to be fixed. Mr Jeffery received the alarm back in the days prior to his death. Ms Campbell stated that despite her father's accident, the alarm did not notify anyone of his accident.[22]

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. In recent years, The Coroners Prevention Unit (**CPU**)[23] has undertaken extensive research into identifying the frequency of deaths involving quad bikes. The CPU identified 33 deaths involving quad bikes that occurred in Victoria between 1 January 2010 and 31 August 2020. I note Mr Jeffery's death falls within the abovementioned period.

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 had concluded, the evidence suggested that 15 deceased were not 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.

[20] E-Medical Deposition Form, Case Reference Number: 2020003507

[21] Statement of Kaye Campbell dated 29 August 2020, Statement of Michelle Reynolds dated 31 August 2020 and

[22] Statement of Kaye Campbell dated 29 August 2020 and statement of Michelle Reynolds dated 31 August 2020.

[23] 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

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 the evidence supports the fact that Mr Jeffery was not wearing a helmet at the time of his collision, that his quad bike did not have a front roll protection bar and that the accelerator had been modified. I am not suggesting that modification of the accelerator by his friend, a retired qualified mechanic, in any way contributed to Mr Jeffery's collision, however, I mention the fact to highlight the lack of regulation around quad bikes. Namely, that there is no requirement for registration and therefore, no oversight over what modifications and upkeep are being made to these vehicles.

5. Off-road vehicles, including quad bikes, are considered to not have been designed for use on public roads. Subsequently, they are not subject to the registration requirements that motor vehicles (cars) and motorcycles are. Currently, VicRoads allows for "*special work vehicles*"[24] to be conditionally registered for road use with strict operating conditions. This is the extent to which any regulatory oversight is placed on these vehicles at present.

6. I note Mr Jeffery was no longer driving his car due to a deterioration in his health. His poor eyesight, his hunch and his hands seizing were all mentioned throughout various statements as to why he no longer drove and had modifications made to his quad bike. The belief that restricting himself to quad bike riding was a safer option, is one that proved fatal.

7. Quad bike riding is by nature, a high-risk activity. Rounding up cattle also has the potential to be a high-risk activity. Mr Jeffery's decision to ride alone, with no safety gear for the purpose of moving his cattle on 27 June 2020, was one that contributed to his devastating outcome.

8. I have included the Minister for Roads and Road Safety and WorkSafe Victoria in the distribution list of this Finding for the consideration as to how deaths such as Mr Jeffery's may be prevented in the future.

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[24] Special Work Vehicles are specialised vehicles primarily constructed and used for off-road transportation in the performance of agricultural, maintenance or service tasks: https://www.vicroads.vic.gov.au/registration/new-registration/register-non-compliant-vehicles/special-work-vehicles

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Kelvin Maurice Jeffery, born 26 December 1923;

    b) the death occurred on 01 July 2020 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052;

    c) I accept and adopt the medical cause of death as ascribed by Dr Brian Beer and find that Kelvin Maurice Jeffery died from blunt chest trauma sustained in a quad bike accident;

2. AND, Having considered all of the circumstances, I am satisfied that Mr Jeffery's death was the consequence of operating and losing control of a modified quad bike with no roll bar and without wearing appropriate safety gear.

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

Pursuant to section 73(1B) 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:

Kaye Campbell, Senior Next of Kin

Kelly Gumm, Trauma Program Manager, The Royal Melbourne Hospital

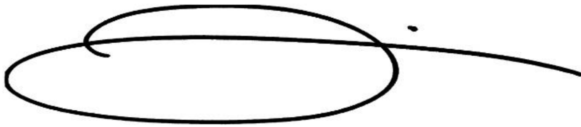
The Hon. Melissa Horne, Minister for Roads and Road Safety

WorkSafe Victoria

LiveLife Alarm

Leading Senior Constable Lynette Jenkins, Coroner's Investigator

Signature:



AUDREY JAMIESON

Date: 28 June 2023

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.