IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005650

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Mathew David West
Date of birth:	5 December 2010
Date of death:	23 October 2021
Cause of death:	1(a) Head and neck injuries sustained in motor vehicle collision (passenger)
Place of death:	Lucyvale Road, Lucyvale, Victoria, 3691
Keywords:	Heavy Vehicles – Rear Underrun Protection

INTRODUCTION

1. On 23 October 2021, Mathew David West was 10 years old when he died in a motor vehicle accident. At the time of his death, Mathew lived in Albury with his mother and father, Emma and David West, and his two brothers.

THE CORONIAL INVESTIGATION

2. Mathew'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 Mathew'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 Mathew's death including evidence contained in the coronial brief. While 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. On 23 October 2023, David planned to drive to Lucyvale with his friend, Craig House, to collect some farm machinery he purchased for the family business. He had hired a tow truck (DAF LF55 Tilt Tray) from Craig for this purpose.[2] It was also arranged that Mathew and his grandfather, Robert West, would accompany David and Craig on the trip, following the truck in a 2012 Toyota Landcruiser wagon. They all left Albury at around 7.30am, with Craig driving the truck and David in the passenger seat, and Robert driving the Landcruiser with Mathew in the front passenger seat.

8. At around 9.30am, Craig was travelling south along Lucyvale Road and approaching the intersection with Coulstons Road, where he planned to turn right. This section of the road is a two-way undivided carriageway with a speed limit of 100 kilometres per hour. Just after the intersection with Coulstons Road, the surface of Lucyvale Road transitions from bitumen to gravel. There is a sign about 50 metres before the intersection to alert drivers to the change in road condition.

9. Craig overshot Coulstons Road and stopped the truck on the left-hand side of the road, about 60 metres past the intersection. The road was of sufficient width for two vehicles to pass by each other. He put on the truck's hazard lights. Robert, driving the Landcruiser, had fallen a little behind the truck and did not observe that it had stopped on the road in front of him as he approached the intersection with Coulstons Road. He did not notice the truck and take evasive action until he had passed onto the gravel road and was only a short distance behind it.

10. When he observed the truck, Robert braked and veered to the right in an attempt to avoid impact. The front left-hand side of the Landcruiser hit the rear right-hand side of the truck. The side of the Landcruiser's bonnet travelled under the tray of the truck, and the tray went through the windscreen of the Landcruiser. Mathew was decapitated and killed instantly.

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[2] The tow truck was fitted with a Tilt and Slide Tray.

11. When interviewed by police after the accident, Robert recalled that he was travelling at less than 80 kilometres per hour before the collision. He stated:

> "*Well, it happened in half a second. We came to the end of the bitumen onto the gravel. My grandson said something to me, or I said something to him, looked ahead, and the bloody truck was stopped. And I tried to miss it, but I couldn't. I thought I had, but I didn't. And it was as simple as that.*"

12. Scott Hay, who was driving north along Lucyvale Road, arrived at the scene of the accident shortly after it occurred. There was no mobile reception so he drove to a neighbouring property to contact emergency services. The Country Fire Authority, Ambulance Victoria and Victoria Police subsequently attended the scene.

13. Craig and Robert both tested negative after undergoing blood alcohol tests administered at Corryong Hospital later in the evening.

14. After receiving advice from the Director of Public Prosecutions, Victoria Police charged Robert with the summary offence of careless driving. He pleaded guilty in the Magistrates' Court at Wodonga on 21 February 2023 and received a 12-month good behaviour bond without conviction.

Identity of the deceased

15. On 23 October 2021, Mathew David West, born 5 December 2010, was visually identified by his father, David West.

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

Medical cause of death

17. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine performed an external examination on 25 October 2021 and provided a written report of his findings dated 26 October 2021.

18. Dr Lynch observed that the head had been traumatically amputated from the upper cervical spine.

19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

20. Dr Lynch provided an opinion that the medical cause of death was 1 (a) Head and neck injuries sustained in motor vehicle collision (passenger).

21. I accept Dr Lynch's opinion.

FURTHER INVESTIGATIONS

22. Detective Acting Sergeant Michael Hardiman of the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) examined the accident scene on 23 October 2021 and prepared a report dated 5 January 2022. His examination included analysis of the Event Data Recorder installed in the Landcruiser. Det A/Sgt Hardiman did not consider that the road surface of Lucyvale Road contributed to the collision. He concluded that Robert commenced emergency braking 1.15 seconds before the collision and between 8 to 16 metres prior to impact. Further, he determined that the Landcruiser was travelling at 63 kilometres per hour before the brakes were applied.

23. On 11 November 2021, the Landcruiser was mechanically inspected by Senior Constable Matthew Craine from the CRMIU. His inspection did not reveal any mechanical fault that would have caused or contributed to the collision.

FINDINGS AND CONCLUSION

24. Mathew's death was the result of a tragic accident. The evidence does not enable me to conclude why Robert did not observe the stationary truck in front him in time to take evasive action and avoid a collision.

25. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Mathew David West, born 5 December 2010;

    b) the death occurred on 23 October 2021 at Lucyvale Road, Lucyvale, Victoria, from head and neck injuries sustained in motor vehicle collision (passenger); and

    c) the death occurred in the circumstances described above.

COMMENTS

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

26. It is possible that Mathew's death may have been prevented if the tow truck involved in the collision had been fitted with Rear Underrun Impact Protection (**RUIP**).

27. Australian Design Rule (**ADR**) 91/00 regulates the use of RUIP on TC/D vehicles (Semi-Trailers). There is no equivalent ADR which regulates the use of RUIP on Heavy Vehicles like the tow truck involved in the collision in this case.

28. Section T of Version 3.2 of the Vehicle Standards Bulletin 6 (**VSB6**)[3] relates to the design and construction of tow trucks. It includes the following recommendation:

> *"If the tilt tray is not fitted with a rear under lift, consideration should be given to mitigate rear underrun, such as minimising rear overhang etc".*

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) The Commonwealth Department of Infrastructure, Transport, Regional Development, Communications and the Arts consider amending *Vehicle Standard (Australian Design Rule 91/00 – Rear Underrun Impact Protection) 2018* to include the regulation of RUIP on Heavy Vehicles.

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

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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[3] Version 3.2 of VSB6 will become operative on 1 July 2023.

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

David & Emma West, Senior Next of Kin

Sergeant Matthew Hunt, Coroner's Investigator

Signature:

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Coroner David Ryan

Date : 29 August 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.