IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000974

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Justin Richard Harris
Date of birth:	12 April 2005
Date of death:	19 February 2023
Cause of death:	1(a) Injuries sustained in an all-terrain vehicle incident (driver)
Place of death:	22 McKillop Road, Mount Evelyn, Victoria, 3796
Keywords:	All-Terrain Vehicle; ATV; Rollover; Seatbelt

INTRODUCTION

1. On 19 February 2023, Justin Richard Harris was 17 years old when he died at home following an All-Terrain Vehicle (**ATV**) collision. At the time, Justin lived in the family home in Mount Evelyn, Victoria, with his parents, Michelle and Robert Harris.

2. Justin was born in 2005 and was an only child. Growing up he was a happy and healthy child who did not have any significant medical history. Justin led a social life and was well-liked and respected amongst his peers and those who interacted with him.

3. Justin enjoyed school and was passionate about sport, in particular basketball. He was also a member of his local Scouts group, and greatly enjoyed participating in camping trips and other outdoor activities with the group.

4. In around 2021, the Harris family purchased an ATV to use around their property, a sumi-rural property on acreage. They had previously owned a quad bike, however upgraded to an ATV due to its ability to tow a trailer which they used to transport firewood and other material around the property. According to Justin's father, the ATV came with three keys, one of which was the 'work key' which electronically limited the ATV's speed. Mr Harris stated the family exclusively used the work key in the ATV.

5. Justin frequently used the ATV around the family property. Mr Harris advised that Justin would not usually fasten the seatbelt while driving the ATV as, when he was using it, he would constantly be getting in and out of it. Mr Harris stated Justin was not inclined to "*hoon*" in the ATV as such behaviour was not within his nature.

THE CORONIAL INVESTIGATION

6. Justin'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.

7. 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.

8. 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.

9. Victoria Police assigned Senior Constable Samuel Flaws to be the Coroner's Investigator for the investigation of Justin'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.

10. This finding draws on the totality of the coronial investigation into the death of Justin Richard Harris 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]

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

Identity of the deceased

11. On 19 February 2023, Justin Richard Harris, born 12 April 2005, was visually identified by his neighbour, Kyla Dobson, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

13. Forensic Pathologist Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Justin's body in the mortuary on 20 February 2023 and provided a written report of her findings dated 3 March 2023.

14. The post-mortem examination and analysis of a post-mortem computerised tomography (**CT**) scan showed extensive injuries to the chest and abdomen consistent with the stated circumstances.

[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.

15. Routine toxicological analysis of post-mortem samples did not detect any alcohol or other commonly encountered drugs or poisons.

16. Dr Francis provided an opinion that the medical cause of death was *1(a) injuries sustained in an all-terrain vehicle incident (driver)*.

17. I accept Dr Francis' opinion.

Circumstances in which the death occurred

18. On 19 February 2023, Justin hosted his new girlfriend, Ms Mollie McGregor, at his family home in Mount Evelyn. It was the first time Mollie had visited Justin's home, so he took her on a tour of the property.

19. At about midday, Justin and Mollie got into the family ATV for a drive around the property with Justin as the driver. As the pair got in, Mollie fastened her seatbelt whereas Justin did not.

20. The ATV in question was a 2020 Can-Am Defender HD8 (**the Can-Am**). It was a 'side-by-side' style ATV, meaning it had a roofed cockpit with a driver and passenger seat, and rollbars. The driver's seat is on the left-hand side of the ATV. The Can-Am did not have any doors however did have side nets which could be fastened on both side entrance points of the Can-Am where a door would traditionally be. At the time of the incident, the side nets were installed on the Can-Am, however they had been rolled up and were not fastened in place.

21. Justin and Mollie headed down the property's driveway on the ATV. The driveway is a single-lane, unsealed gravel stretch of road several hundred metres in length. In the direction that Justin and Mollie were headed away from the house and towards McKillop Road, the driveway sloped downwards. The right side of the driveway is bordered by a steep gutter and the left side is abutted by a grass verge which at the relevant section slopes steeply towards a wire fence with wooden poles.

22. As Justin and Mollie headed down the driveway and approached a right-hand curve, a gust of wind caused Justin's hat to fly off. The evidence suggests Justin was momentarily distracted by the hat which caused him to lose control of the ATV. According to Mollie, *"As the hat was falling, he tried to catch it and that's when the ATV came off the driveway."*

23. The ATV failed to negotiate the right-hand curve and left the surface of the driveway on the outside (left) of the curve. The ATV rolled over and landed on the driver's side before coming

to a rest against the wire fence, still on its side. At some point during the rollover, Justin became separated from the ATV and suffered serious injuries. Despite the rollover, Mollie who was wearing her seatbelt on the passenger side, remained fixed in place inside the Can-Am's cockpit.

24. Mollie freed herself from the ATV and immediately attended to Justin who was unconscious and unresponsive. She yelled out for assistance and contacted emergency services. Several of Justin's neighbours responded to Mollie's yells, attended the scene, and commenced cardiopulmonary resuscitation (**CPR**) on Justin.

25. Ambulance Victoria paramedics arrived at the scene at 12.53 pm and found Justin in cardiac arrest with multiple injuries to the head and chest. Paramedics continued resuscitation efforts and administered oxygen. Tragically and despite all efforts, Justin was unable to be revived and he was verified deceased at the scene.

26. At the time of the incident, the weather was clear and the driveway surface was dry. Justin was not wearing a helmet or any other protective gear.

27. Victoria Police members attended and performed a scene examination. Attending members noted the driver's side seatbelt was fastened which suggests it had been improperly secured and that Justin had sat on top of it. The Can-Am had two range settings, 'high' and 'low.' The gear selector following the incident was found to be in the 'high' range position.

28. Attending police considered the ATV appeared to be in good condition with sufficient tread on the tyres. Rolling tyre marks were embedded in the gravel driveway leading into the collision site which indicated the ATV ran directly off the driveway without any evidence of emergency braking.

29. Police were unable to ascertain the speed the ATV was travelling at when it lost control and left the driveway. In her statement included in the coronial brief, Mollie stated *"We weren't zooming down, just going normal pace."*

30. Having investigated the circumstances surrounding Justin's death and provided the brief of evidence on which this finding is based, Senior Constable Samuel Flaws did not believe that Justin was driving at an excessive speed or otherwise driving erratically immediately prior to the incident.

FURTHER INVESTIGATIONS: CAN-AM OPERATOR MANUAL

31. As part of my investigation into Justin's death, I requested and obtained a copy of the operator's manual[2] for the Can-Am ATV as driven by Justin.

32. The manual contains multiple warnings that the vehicle can be hazardous to operate and explicitly warns of the risk of sudden rollovers. The first page of the manual includes the following warning:

> ***YOUR VEHICLE CAN BE HAZARDOUS TO OPERATE****. A collision or rollover can occur quickly, if you fail to take proper precautions, even during routine manoeuvers such as turning and driving on hills or over obstacles. For your safety, understand and follow all the warnings contained in this Operator's Guide and on the labels on your vehicle.* ***Failure to follow these warnings can result in SEVERE INJURY OR DEATH!***
> *Keep this Operator's Guide with the vehicle at all times.*

33. The manual recommends that the operator and any passengers wear a suitable helmet, gloves, closed toe footwear, and other safety gear at all times when in the ATV.

Gear Selection and Key Type

34. The Can-AM ATV is provided with three separate keys, the work key, the normal key, and the performance key. The work key limits the Can-Am to 40 km/h, however, the manual recognises that higher speeds may be achievable on steep declines. Mr Harris provided evidence that Justin and the family only used the work key with their Can-Am and I am satisfied that at the time of the collision, Justin was travelling at no more than 40 km/h.

35. Attending police observed that the gear selector was positioned in the high range position. The manual states that high range is the default drive mode, and that low is to be used as an alternative when towing or traversing steep hills.

Warnings and Safety Advice

36. Under a section titled 'Avoid Accidents,' the manual states that side-by-side ATVs are designed to handle off-road terrain and as a result are prone to rollovers. To mitigate the danger of a rollover, the manual recommends that the side nets be tightly equipped whenever

[2] Can-Am Defender Series Traxter Series Operator's Guide 2020 herby referred to as '*the manual*'.

the ATV is in use and seatbelts be fastened to reduce the risk of occupants being ejected in the case of a rollover.

37. There are two warning labels in yellow and black print on the front facing section of the inside of the roof on the driver's side of the Can-Am. The first label warns that rollovers have caused serious injury and death even on flat, open areas. The second label warns generally that improper use of the Can-Am can result in serious injury or death and advises to fasten seatbelts, ensure the side nets are latched in place, and to wear safety gear. The manual states that if these safety labels become damaged, Can-Am will replace them free of charge.

Seatbelt safety system

38. The Can-Am ATV is equipped with three-point seat belts for the driver and passenger. In the event the ignition is turned on, the vehicle is in park, and the driver's seat belt is not fastened, a seatbelt warning light on the dashboard will flash.

39. If the gear selector is moved out of park and the driver's seatbelt is still not fastened, the maximum speed of the Can-Am is electronically limited to 20 km/h, although higher speeds may be reached on declines. In this occurrence, the Can-Am's dashboard displays the following message *"ENGINE LIMITATION ENGAGED FASTEN SEAT BELT"*

40. The evidence suggests that Justin latched his seatbelt on 19 February 2023 underneath him and without placing it across his body and waist. In all likelihood, this was to circumnavigate the above seatbelt safety features.

41. Having reviewed the Can-Am operator's manual, I am satisfied that the Can-Am ATV is sold with ample and appropriate warnings for what is an inherently dangerous piece of machinery.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Justin Richard Harris, born 12 April 2005;

    b) the death occurred on 19 February 2023 at 22 McKillop Road, Mount Evelyn, Victoria, 3796;

    c) the cause of Justin's death was injuries sustained in an all-terrain vehicle incident (driver); and

d) the death occurred in the circumstances described above.

43. I am satisfied that the cause of the collision was Justin being momentarily distracted by his hat which caused the ATV to unexpectedly leave the driveway and rollover. The evidence does not support a finding that Justin was travelling at excessive speed or was otherwise driving in a dangerous or careless manner.

44. I find it likely that Justin's failure to adhere to the Can-Am recommended safety precautions, namely his failure to wear a seatbelt, wear protective gear and secure the side nets, were a significant contributing factor to the injuries he sustained. This is evidenced by Mollie who wore a seatbelt and was able to walk away from the incident relatively unscathed.

COMMENTS

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

45. The inherent dangers of ATVs, and similarly quad bikes, are well-documented in the coronial jurisdiction and have long been a concern to coroners throughout Australia.

46. In Victoria, Coroner John Olle completed a cluster inquest finding into seven quad bike deaths in April 2009.[3] Coroner Olle made recommendations that WorkSafe Authorities in Victoria and Tasmania work with the Consumer Affairs Authorities to ensure that quad bikes are not sold to or operated by persons who have not completed a certified training program, and recommended that the WorkSafe Authorities investigate and develop, in conjunction with quad bike distributors and FarmSafe, a Certified Training Program for quad bike use.

47. More recently, Coroner Audrey Jamieson completed a finding into an agricultural quad bike death of an elderly man.[4] Although this matter can be clearly distinguished on a number of fronts to Justin's case, Coroner Jamieson made relevant comment about the registration requirements for off-road vehicles:

> *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*

[3] Joint inquest in Victoria conducted by Coroner John Olle, findings delivered 17 April 2009 re death of Patricia Murray Simson Case No 3679/02 and others.

[4] Finding Into the Death Without Inquest of Kelvin Maurice Jeffery.

allows for "special work vehicles"[5] 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.

48. In previous years, the Coroners Prevention Unit (**CPU**)[6] has monitored 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.

49. 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 wearing a helmet at the time of the incident.

50. This analysis shows that deaths involving quad bikes and similar off-road vehicles such as ATVs remain an ongoing public health and safety issue in Victoria.

51. It ought to be recognised that most of the studies in this area focus on quad bikes, and not specifically ATVs as involved in Justin's death. Nonetheless, quad bikes and ATVs share a number of innate qualities, both in their use in regional and agricultural settings and the significant risk posed by rollovers.

52. Justin's case highlights the need to exercise caution at all times when driving an ATV, the importance of using all the available safety features including seatbelts and side netting, and the need to wear appropriate safety gear.

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.

[5] 4 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/newregistration/register-non-compliant-vehicles/special-work-vehicles

[6] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

I convey my sincere condolences to Justin's family and friends for their tragic loss. Justin's father provided a moving account of his son's life and it is clear that he is dearly missed by those around him.

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

Michelle & Robert Harris, senior next of kin

Senior Constable Samuel Flaws, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date : 01 November 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.