IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006832

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	RD
Date of birth:	10 October 1972
Date of death:	23 November 2024
Cause of death:	1a : Head Injury Sustained in a Side-By-Side Vehicle Incident (Driver)
Place of death:	[redacted] Ullina Victoria 3370
Keywords:	All-Terrain Vehicle, ATV, Utility Terrain Vehicle, UTV, Side-by-Side Vehicle, SSV, Rollover

INTRODUCTION

1. On 23 November 2024, RD (**Ms D**) was 52 years old when she died at her home following in a side-by-side vehicle (**SSV**) collision. At the time, Ms D lived in Ullina Victoria with her husband Mr TD (**Mr D**).

2. In 2009, Ms D married Mr D and they settled in Ullina ([redacted]). Ms D had a successful career and enjoyed spending time with her family. She devoted time to maintaining [redacted] which sat on acreage.

3. Ms D and Mr D owned an SSV which they used around their property which featured several private tracks and driveways. Ms D held a current driver's license with no traffic offences recorded.

4. Ms D had an unremarkable medical history.

THE CORONIAL INVESTIGATION

5. Ms D'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms D's death. The Coronial 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.

9. This finding draws on the totality of the coronial investigation into the death of Ms D 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

10. On 23 November 2024, RD, born 10 October 1972, was visually identified by her friend, GV who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 25 November 2024 and provided a written report of his findings dated 27 November 2024.

13. The post-mortem computerised tomography (**CT**) scan revealed a fracture to the base of skull (left occipital bone, right temporal) with pneumocephalus (air within the cranial cavity). The post-mortem examination showed extensive injuries to the face and skull including the following, an abraded injury to left cheek extending from the left lower eyelid across the left cheek, right periorbital haematoma involving the right upper eyelid, tear of the medial aspect of the right internal helix of the right ear.

14. Toxicological analysis of post-mortem samples detected ethanol (alcohol) at an elevated concentration of 0.28 g/100mL of blood, and 0.31g/100mL of vitreous humour.[2]

15. Dr Michael Burke provided an opinion that the medical cause of death was *1(a) Head injury in all- terrain vehicle incident.*

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[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.

[2] Vitreous humour is the clear gel that fills the space between the lens and retina of the eyeball. Generally, toxicological analysis of vitreous humour provides a better indicator or perimortem levels than post-mortem blood.

16. I accept Dr Michael Burke's opinion as to the cause of death, save that for reasons discussed below, I have determined that it is appropriate to change the cause of death to *1(a) Head injury sustained in a side-by-side/utility terrain vehicle incident.*

Circumstances in which the death occurred

17. On the weekend of 22 to 24 November 2024, Ms D and Mr D hosted six friends at [redacted].
18. During the morning of 23 November 2024, Ms D, her husband and their guests enjoyed breakfast together and helped Mr D with his backyard renovations. At about 12.00 pm, the group each had a glass of champagne before going to a restaurant in Daylesford for lunch. At about 12.30 pm, the group arrived at the restaurant where they spent the afternoon having lunch, drinking alcohol and coffee.
19. At about 5.30 pm, the group returned to [redacted] and went to a lookout at the property to watch the sunset. At this time, everyone was drinking wine.
20. Soon after, Ms D drove two of their guests back to the house in the SSV while Mr D and four other guests drove down to a dam in his utility vehicle.
21. Ms D's SSV was a 2024 CF Moto UForce600. It was a selectable, four-wheel drive, two-seater off road SSV, fitted with a single cylinder, 600 cubic centimetre (**CC**) petrol engine with an automatic transmission. It had a roll cage with roll-over-protection, seatbelts and occupant restraint safety netting. As an added safety feature, the vehicle was speed limited to approximately 30 kilometres per hour (**km/h**) if the seat belt was not latched.
22. Ms D dropped the guests off at the house and left alone on the SSV some 15 minutes later. It is unclear where she was going or what she was planning to do. When Mr D and the other four guests returned to the house at about 6.15pm, Ms D was not there. About 20 minutes later, Mr D and one of the guests began looking for Ms D.
23. They found Ms D on the property's driveway, trapped under the SSV, which had rolled on top of her. The driveway is 50 meters long and is constructed from crushed white rock. It begins at the entrance of the property and extends inwards in a horseshoe shape. The collision occurred on the right-hand side of the driveway leading up to the residence and the collision site was note visible from the house.
24. It appears that as the vehicle rolled, Ms D was ejected from the front of SSV into bushes alongside the gravel driveway. Mr D used his utility vehicle to push the SSV off Ms D and found her she was unresponsive. The guest commenced cardiopulmonary resuscitation (**CPR)** as Mr D went back to the house to get help. He returned to the collision scene with other guests who joined the resuscitation efforts.

25. Ambulance Victoria paramedics arrived at the scene at 7.15 pm and took over resuscitation of Ms D at about 7.18 pm. However, despite all efforts Ms D was unable to be revived and was verified deceased by paramedics at the scene at 7.45 pm.

26. The paramedics observed that Ms D did not appear to be wearing a helmet nor was she wearing a fastened seatbelt at the time of the collision. Moreover, the side safety harnesses on the SSV were not fastened in place.

VICTORIA POLICE INVESTIGATION

27. Senior Constable Daivd Guilieri (**SC Guilieri**) of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit conducted a mechanical inspection on Ms D's SSV and provided a report dated 7 February 2025 that was included in the coronial brief.

28. SC Giulieri concluded that the seatbelt and safety netting were not used by Ms D at the time of the collision. Damage to the SSV was consistent with the collision (as described above) and inspection of the SSV did not reveal any faults, failures or conditions that could have caused or contributed to the collision.

29. Coronial investigator, Senior Constable Craig Gilbert considered the circumstances of the SSV collision in which Ms D sustained fatal injuries and expressed the opinion that a lack of safety measures, and a blood alcohol concentration well above the Victorian legal driving limit combined to cause the fatal incident.

THE SAFETY OF SIDE-BY-SIDE VEHICLES

30. At the of Ms D's death, it was initially believed that she was driving an All-Terrain Vehicle (**ATV**) – colloquially known as a *'quad bike'*. However, during the course of the coronial investigation, it has become apparent that the vehicle was, in fact, a side-by-side vehicle (**SSV**), also known as a utility terrain vehicle (**UTV**).

31. Ms D's death forms part of a broader pattern of deaths associated with ATVs and similar vehicles. For present purposes, an ATV, is a motorised single rider, off road vehicle. It has a seat designed to be straddled by the operator, handlebars for steering control, and travels on four wheels.[3]

[3] Australian Competition & Consumer Commission (ACCC) Product Safety '*Quad Bikes Guide'*. Accessed 10 July 2025. Accessible at: <https://www.productsafety.gov.au/consumers/drive-and-ride-safely/quad-bikes-guide>.

32. An SSV or UTV, differs from an ATV in that it has a bench seat for passengers, is fitted with seat belts, has rollover protection and a higher load capacity.4 The load in an SSV is commonly carried below the top of the tyres, which contributes to the vehicle's lower vertical centre of gravity.5

33. Several coronial comments and recommendations have been made regarding the safety of ATVs. In recent years, coroners and other public safety organisations have focussed their attention on ATVs and their association with serious injury or death. There has been less focus on the dangers associated with SSVs.

34. It appears that not only the Victorian community, but Australians in general, consider SSVs or UTVs as a *'safer'* alternative to ATVs. However, the circumstances of Ms D's death illustrate that they are not free of risk.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was RD, born 10 October 1972;

b) the death occurred on 23 November 2024 at [redacted] Ullina, Victoria 3370;,

c) the cause of Ms D's death is *1(a) head injury in a side-by-side/utility terrain vehicle incident*; and

d) the death occurred in the circumstances described above.

36. The available evidence supports a finding that Ms D was the sole occupant and driver of an SSV/utility terrain vehicle on a private driveway at the time of the collision when she lost control causing the vehicle to roll and eject her such that she suffered the fatal head injury to which she succumbed and that her elevated blood alcohol concentration was a probable cause or contributory factor in the collision.

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[4] SafeWork New South Wales, '*Side-by-Side Vehicles Fact Sheet'*, Accessible at: https://www.safework.nsw.gov.au/resource-library/agriculture,-forestry-and-fishing-publications/quad-bike-pubs/side-by-side-vehicles-fact-sheet>.

[5] Australian Competition & Consumer Commission (ACCC) '*Quad Bike Safety'*, 13 November 2017). Accessible at: < chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://consultation.accc.gov.au/product-safety/quad-bike-safety-investigation/supporting_documents/ACCC%20Quad%20Bike%20Safety%20Issues%20Paper.pdf >.

37. Further, the evidence supports a finding that Ms D was not wearing a seatbelt or utilising the safety netting that was a feature of the vehicle, nor was she wearing a safety helmet. Any one or a combination of these safety features had the potential to change the fatal outcome in this case and prevent her death.

38. I convey my sincere condolences to Ms D/s family for their loss.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments in connection with the death:

Cluster Inquest into Nine Deaths Involving ATVs and SSVs in New South Wales

39. On 26 November 2015, New South Wales Deputy State Coroner, Magistrate Sharon Freund, handed down her finding following a cluster inquest into nine deaths involving ATVs and SSVs.[6]

40. Magistrate Fruend discussed that while SSVs are fitted with more safety features than ATVs (including seatbelts, roll over protections and safety harnesses), it is imperative that drivers make use of this equipment to reduce the risk of serious injury or death. Her Honour stated:

> *"The roll-protection structure of an SSV is only beneficial in reducing or preventing death or injury if a seatbelt is worn by the occupant(s) of the vehicle. If a seatbelt is not worn, the occupant(s) of the SSV will not be contained within the vehicle in the event of a rollover. In such event, the occupant will be at risk of crush or other injury both from the SSV and, indeed, from the rollover protection itself".*

41. Evidence heard at the NSW inquest indicated that ATVs are vulnerable to rollover and further, that SSVs are also prone to rollover, including when on flat ground.[7]

42. Magistrate Freund identified that driver's actions can and do contribute to ATV and SSV fatalities. Her Honour held that failures to heed manufacturing warnings including the use of helmets, seatbelts, and avoiding driving the vehicle under the influence of alcohol, played a causative or contributory role in many of the deaths which were the subject of the inquest.[8]

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[6] Inquests into the deaths of Donald Eveleigh, Angela Stackman, FW, ML, Anthony Waldron, Colin Reid, Bradley Jackson, Robert Beamish and LE. Magistrate Fruend, 26 November 2015. Accessible at: <https://coroners.nsw.gov.au/download.html/documents/findings/2015/Quad%20bike%20findings%20v2.pdf>.
[7] Ibid.
[8] Ibid.

43. Magistrate Freund made several recommendations regarding safety rating(s), helmets, seatbelts, and advertising/education.[9] I note that many of these recommendations were targeted towards SafeWork NSW and focussed on the use of ATVs and SSVs in work-related and/or agricultural contexts.

44. While Magistrate Freund's recommendations were, for the most part, well received, the NSW government declined to consider making helmets mandatory for ATVs, SSVs and related vehicles, stating that it was *'not appropriate to legislate the use of helmets'*.

Coroners Prevention Unit Surveillance Database

45. To better understand the prevalence of SSV/UTV-related deaths, I sought the assistance of the Coroners' Prevention Unit to provide any data about deaths arising from the use of ATVs and SSVs in recent years.

46. The search conducted across the Court's surveillance database(s) identified 39 deaths, which fit the criteria and of deaths occurring in Victoria between 1 January 2015 and 30 June 2025.

47. From the surveyed period, the data showed that 12 deaths (30.7%) involved SSVs. Of 31 deaths where relevant evidence was available, only one deceased was wearing a helmet at the time of the incident. Of 24 cases (61.5%) deaths where evidence was present, none the deceased were wearing a seatbelt. In 12 cases (30.7%) of the reported deaths the deceased had alcohol in their system.

48. When compared to ATV-related deaths occurring during the same period, deaths attributed to either vehicle in previous years, have been generally comparable. In 2023, ATVs were responsible for three deaths, compared to one death associated with an SSV. In 2024, there were two deaths related to ATVs and three deaths associated with SSVs.

49. Over recent years, Victorian authorities have released information regarding the safe use of UTVs. WorkSafe Victoria published safety alerts about SSVs, which highlights the importance of managing the risks of operating these vehicles, and addresses ways to mitigate these risks. These include the use of helmets,[10] seatbelts and other safety features.[11] Similar

[9] Ibid.
[10] WorkSafe Victoria, '*Side-By-Side Vehicle Safety',* 02 June 2020. Accessible at: <https://www.worksafe.vic.gov.au/safety-alerts/side-side-vehicle-safety>.
[11] WorkSafe Victoria, *Side-By-Side Farm Vehicles: Don't Ignore the Seatbelts*, 23 September 2021. Accessible at: <https://www.worksafe.vic.gov.au/safety-alerts/side-side-farm-vehicles-dont-ignore-seatbelts>.

organisations in other Australian jurisdictions have also published information about reducing the risks associated with SSVs.[12]

AgriFutures Australia Statistics

50. At the time of writing, most of the safety information regarding SSVs, relates primarily to their use in agricultural work. However, recent data released by AgriFutures Australia reveals a sharp and concerning rise in on-farm fatalities.[13] The 2024 statistics more than doubled the fatalities recorded nationwide in 2023 with 14 deaths arising from the use of SSVs and 10 deaths arising from the use of quad bikes.[14]

51. I note that Ms D was using her SSV in a private setting and this highlights the importance of SSV-related safety education for the broader public - not only for those engaged in agricultural pursuits.

52. In the interests of public safety, I direct that a copy of this finding be provided to the Department of Transport Victoria and the Australian Competition and Consumer Commission for their reference and consideration of this issue.

[12] WorkSafe Western Australia, '*Reducing the Risk When Using Side-By-Side Vehicles: Information Sheet'*, 30 January 2025. Accessible at: <https://www.worksafe.wa.gov.au/publications/information-sheet-reducing-risk-when-using-side-side-vehicles>.
[13] AgriFutures Australia, '*Sharpe Rise in Farm Injuries Sparks Urgent Safety Warning'*, 5 March 2025. Accessible at: < https://agrifutures.com.au/news/sharp-rise-in-farm-injuries-sparks-urgent-safety-warning/ >.
[14] Ibid.

AMENDMENT OF CAUSE OF DEATH

Pursuant to section 49(2) of the Act, I direct that the Principal Register notify the Registrar of Births, Deaths and Marriages to amend the cause of death, namely *"1(a) Head injury in a side-by-side vehicle incident'.*

PUBLICATION OF FINDING

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.

DISTRIBUTION OF FINDING

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

TD, Senior Next of Kin

Australian Competition & Consumer Commission

Department of Transport Victoria

Senior Constable Craig Guilbert, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 25 July 2025

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.