IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000791

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Steven James Lawrie
Date of birth:	06 April 1974
Date of death:	11 February 2021
Cause of death:	1(a) EFFECTS OF FIRE IN THE SETTING OF A MOTOR VEHICLE INCIDENT (DRIVER)
Place of death:	Western Highway, Serviceton, Victoria, 3420

INTRODUCTION

1. On 11 February 2021, just over two hours after South Australia enforced a snap COVID hard border closure with Victoria, Steven James LAWRIE, 46 years old, passed away in a heavy vehicle truck collision and subsequent fire on the Western Highway at Serviceton, approximately six kilometres east of the South Australian border vehicle checkpoint. At the time of his death, Steven lived at Parafield Gardens, South Australia.

THE CORONIAL INVESTIGATION

2. Steven'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 Detective Leading Senior Constable Lucilla McCallum, Major Collision Investigation Unit to be the Coroner's Investigator for the investigation of Steven's death. The Coroner's Investigator conducted inquiries on my behalf, including but not limited to taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. These enquiries also included requests for information from numerous agencies inter-state primarily South Australia Police.

6. This finding draws on the totality of the coronial investigation into the death of Steven James LAWRIE 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. On 5 February 2021 border checking stations (or border checkpoints) were reactivated by South Australia Police on the Victoria/South Australia border, following reports the previous day of an outbreak of COVID-19 from Hotel Quarantine in Victoria. The *Emergency Management (Cross Border Travel No 34) (COVID-19)* Direction 2021 (under section 25 of the *Emergency Management Act 2004* (SA)) (**Direction #34**) was made on 4 February 2021 at 6.16pm and had operated from that time. This introduced quarantine and testing requirements for relevant Victorian arrivals but did not prohibit their entry into South Australia.[2]

8. At 12.01am on 11 February 2021, *Emergency Management (Cross Border Travel No 36) (COVID-19) Direction 2021* (under section 25 of the *Emergency Management Act* 2004 (SA)) (**Direction #36**) came into force. This direction was made in response to the worsening COVID-19 situation in Victoria and prohibited entry to any person who:

    a) had been in Greater Melbourne on or after 12.01am on 4 February 2021; or

    b) had been at the Melbourne Airport Holiday Inn on or after 12.01am on 27 January 2021; or

    c) was a close contact of a person mentioned in paragraph (b).

    The only exception were "*essential travellers*" and certain other exempted categories of people defined in the Direction #36 border closure. The Serviceton checkpoint where the Western Highway (Vic) meets the Dukes Highway (SA) on the South Australia-Victoria border, already operational and reactivated from 5 February 2021, transitioned immediately to this 'hard' border closure as at 12.01am on 11 February 2021.[3]

9. On the evening of 10 February 2021, Steven was driving a Volvo cab over prime mover that was towing a tautliner A trailer and pantech B trailer for Transport Training Solutions Pty Ltd. He had been employed at this company since 10 July 2020 when he had been interviewed for a novice MC driver, predominantly for interstate driving, commencing a Certificate III Traineeship in Driving Operations. At the time of his passing Steven had completed 280 hours

[2] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p311.
[3] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp312-313.

of the requisite 470 hours of the Certificate III.[4] Since November 2020 Steven had been undertaking the Nhill changeover route, five times a week. He would leave Wingfield, South Australia between 8.00pm-9.00pm, arrive at Nhill, Victoria (365kms, 4½ hours) where he would exchange trailers with a Victorian truck, have a rest break, and then travel back to Wingfield arriving between 5-6am the following morning.[5] GPS data indicates that Steven departed StarTrack, Wingfield (South Australia) at 8.36pm that evening and drove towards Nhill (Victoria).

10. Alan and Rosie Lawrie, Steven's parents, last spoke with him on the phone that night, between 10.35pm-11.39pm. It was habit that every day when Steven was driving his parents would call him, usually around 10pm and talk for about an hour. On this final occasion Alan was of the opinion that '*there was nothing that stood out about the call. We were just talking in general as usual and he seemed quite happy. He mentioned that his changeover driver was running about half an hour late so he was going to have a snooze before he swapped the trucks over*'.[6] Steven's truck was stationary for a 15-minute period, between 11.52pm on 10 February and 12.07am on 11 February, whilst he had a rest break.

11. That evening Gaganpreet Guraya, a truck driver with Linfox and Startrack commenced his shift about 8.30pm, attended the Tullamarine depot (Victoria) and after hooking up his trailers into a B-double combination and conducting the necessary pre-drive checks, departing the Tullamarine depot approximately 9.30pm. Gaganpreet arrived in Nhill around 1.30am and met up with Steven and exchanged trailers. Gaganpreet gives evidence that '*we hooked up the trailers and checked the trailers. After that I was tired and I took a power nap of about half an hour. After about five minutes, Steven left. I think he left at about 1:40-1:45, something like that. I would normally have a chat with him for about five to seven minutes when we swapped over the paperwork, but I was tired this night so I was not feeling like a chat. Because we did not have a chat that night I can't say whether he was ok or not*'.[7] GPS data indicates that Steven arrived at the Nhill trailer exchange location at 1.26am and commenced the return trip back towards the South Australian border and the trucking home depot at Wingfield, South Australia at 1.40am.

[4] Affidavit of Senior Constable Rachel Sarvas, South Australia Police, Inquest Brief, p567.
[5] Statement of Peter Simmons, Inquest Brief, p254.
[6] Statement of Alan Lawrie, Inquest Brief, p89.
[7] Statement of Gaganpreet Guraya, Inquest Brief, p262.

12. Marcus Vonzieden, a self-employed truck driver that evening was undertaking a very similar trucking route to Steven (albeit that he was not employed by the same company). He departed Athol Park, Port Adelaide around 6pm and headed towards Nhill driving a Volvo B-Double combination. Marcus gives evidence that '*I crossed the SA border into VIC at about 9.20pm. When I crossed the border there were no restrictions in place and no indication that there was going to be*'.[8] He then attended the Nhill trailer changeover point and stayed there for around half-an-hour. He gives evidence that '*while we were having our break, I noticed an increase in traffic and cars which is unusual for that time of night. This was at about 11.30pm VIC time. That's when we realised the border was closing at midnight. I'm not sure if it was midnight SA time or VIC time. I jumped in the truck and took off because I wanted to get back over the border before the border closed and the line ups started*'.[9] Marcus indicated that as he was travelling through Kaniva he heard over the UHF that there was a line-up of traffic at the border. As he was some kilometres from the South Australian border he came across a stationary line-up of traffic and was forced to bring his B-double combination to a stop. Upon stopping he activated the hazard lights on his trailer combination so that the traffic behind him could see that he was stopped. Marcus had been stationary in the traffic lineup for about 20 minutes when a truck approached from the opposing direction and had either LED or HID lights that momentarily blinded him. '*The next thing I remember I heard someone say he's not slowing down over the UHF. Followed by a bang … … I heard the bang, looked in the mirror and saw a white cloud and then the fire started. It was about 200 metres behind me*'.[10]

13. That evening, Robert Rodda, an interstate truck driver with Graham Collins Transport was driving along the Western Highway, Serviceton towards the South Australia border. He was driving a Western Star conventional prime mover towing two loaded tautliner trailers in a B-Double combination. He had departed Altona, Victoria and driven to Nhill arriving at 1.00am having a half-hour break at the Caltex Service Station before continuing towards Pooraka, South Australia.

14. Robert gives evidence that '*I was listening to the UHF radio on channel 40 from when I previously went through Horsham. Everyone was talking about the long line up to the border crossing … … they were saying the border was closed to cars from midnight … … I was told over the UHF radio the line up was about 6 kilometres long and the traffic was at a stop*'.[11]

[8] Statement of Marcus Vonzieden, Inquest Brief, p265.
[9] Statement of Marcus Vonzieden, Inquest Brief, p265.
[10] Statement of Marcus Vonzieden, Inquest Brief, p266.
[11]

As Robert approached the stationary line-up of traffic at the border he observed the last vehicle being a B-Double combination with its hazard lights activated. Robert brought his truck to a stop approximately ten (10) metres away and then activated his hazard lights and saw that the truck in front then turned his hazard lights off.

15. That evening Ali Raza Naib, an interstate truck driver with Tremco Bulk Transport Pty Ltd was driving along the Western Highway, Serviceton towards the South Australian border. He was driving a Kenworth cab over prime mover towing two loaded tautliner trailers in a B-Double combination. He had departed Somerton, Victoria approximately 9.00pm enroute to Perth driving in tandem with his colleague, Kevin Woodward, to enable the truck to be driven non-stop swapping drivers approximately every six hours.

16. Approximately 2.15am (AEDT) Ali was approaching the border when he observed a long line of traffic (at the time Kevin Woodward, his tandem driver, was asleep). He gives evidence '*whilst approaching the border I didn't see warning signs to indicate the checkpoint was ahead. Previously when I travelled through the checkpoint there was signs to indicate the checkpoint was ahead but this was usually only approximately 500-600 metres before the checkpoint … … I recall hearing some talk on the two way (CB radio) as I approached from other truck drivers complaining about the traffic … … I don't recall hearing any warnings or notifications about the traffic prior to arriving*'.[12] Ali noted that '*the conditions were clear and weather was fine as I approached, I had no visibility issues'.* As he approached the stationary line-up of traffic Ali saw Robert Rodda's B-Double combination stopped in front of him with his hazard lights activated. Ali stopped approximately three car lengths back from Rodda's B-Double combination, applied the handbrake and activated his hazard lights '*so any trucks behind could see me stopped ahead*'.[13] Ali checked his side rear vision mirror and confirmed that his hazard lights were illuminated and observed they were flashing behind him in the dark. Shortly thereafter Robert Rodda turned his hazard lights off as Ali's truck was now the last truck stationary in the line.

17. Ali sat in the truck cabin waiting for a couple of minutes, keeping his foot on the brake but took his seatbelt off as he needed to urinate and knew he would be there for some time and therefore would have to exit the truck at some stage. Ali then observed Steven's truck approaching from behind in his driver's side rear view mirror. He estimated that Steven '*was approximately one kilometre away from me and was approaching at a normal speed that I'd*

[12] Statement of Ali Raza Naib, Inquest Brief, p275.
[13] Statement of Ali Raza Naib, Inquest Brief, p275.

expect for him to stop. I could only see the trucks lights as it approached. It only had its normal driving lights illuminated, not its high beams. As the truck was approaching I didn't see any brake lights illuminating from the rear. Usually in the dark when a truck is approaching you can see its rear brake lights illuminating from the front as it glows towards the rear of the truck'.[14]

18. Ali still had his foot on the brake and had looked away from the mirror for a second to have a drink when he heard a huge thud before feeling an impact from behind. Steven's Prime Mover had impacted with the rear of Ali's B-Double combination, forcing Ali's Prime Mover into the back of Robert Rodda's trailer combination, causing Ali's windscreen to shatter and the cabin to be partially damaged.

19. Ali, Kevin and Robert were all able to exit the cabins of their respective trucks and saw that Steven's cabin as well as the B-trailer of Ali's B-Double combination were totally engulfed in flames. Due to the intensity of the ensuing fire there was no opportunity whatsoever of extracting Steven from the wreckage. Robert prior to the fire spreading was able to unhook the trailer combination from his Prime Mover and move the Prime Mover forward prior to the spreading fire engulfing the entirety of Steven and Ali's B-Double combinations as well as the trailers from his own B-Double combination.

20. Numerous members of the public on-scene at the crash site rang Triple Zero with the first recorded telephone call being received at ESTA at 2.21.47am (AEDT). Emergency Services were immediately activated including the Victorian Country Fire Authority, Victoria Police, South Australia Police, South Australia Country Fire Service, State Emergency Service and South Australian Ambulance Service and attended the collision scene immediately closing down the Western Highway at the location. Road diversions were implemented to prevent vehicles travelling along the Western Highway in either direction, securing the area as a crime scene.

21. The Major Collision Investigation Unit (MCIU), Victoria Police were activated with Detective A/Sergeant McCallum, Detective Senior Constable Nelson and Detective A/Sergeant Frith attending the collision scene arriving approximately 3.15pm on Thursday 11 February.

[14] Statement of Ali Raza Naib, Inquest Brief, p276.

22. The Disaster Victim Identification (DVI) Unit within Victoria Police were also activated due to the specialist forensic knowledge required to extract Steven's heavily burnt body from the wreckage of his prime mover, and to also confirm that there were no other occupants.

23. D/A/Sergeant Frith conducted a preliminary examination of the scene and observed '*the Western Highway was a single bitumen carriageway that ran in a generally east to west orientation, there was single lane for vehicles to travel in either direction, a solid white fog line defined the outer edges of the running lanes with a wide bitumen shoulder abutting the fog line on either side of the carriageway, wire rope barriers adorned the edges of the bitumen carriageway with grassed and treed verges beyond the wire rope barrier and edges of the bitumen. The opposing lanes were separated by two parallel broken white lines painted down the approximate centre of the road surface, there was a space of approximately 1.2 metres between the broken white lines*'.[15]

24. D/A/Sergeant Frith went on to observe '*for vehicles travelling generally west, the road descended from a crest in the road, approximately 1100 metres east of the collision scene, to a flat section of road leading to the collision scene. A westbound overtaking lane adjoined the westbound running lane, prior to the crest, and terminated on the flat section of road, approximately 450 metres east of the collision scene. The road was dry, the weather was fine and hot, and visibility was good. The area would best be described as rural farming and a speed limit of 100km/h was applicable. Debris from the trucks was strewn across almost the entire road. The B (Rear) trailer of the third truck in the line (offending vehicle), was partially burnt and it was evident that the side walls and contents of the trailer had been removed to help extinguish the blaze. The A (Front) trailer and prime mover of this truck, both trailers and prime mover of the middle truck, and both trailers of the front truck, had been totally destroyed by fire*'.[16]

25. D/A/Sergeant Frith identified by a series of scrape, gouge and tyre scuff marks in and on the road surface an area of impact that was immediately behind the rear of the B trailer of Steven's truck. He opined '*these marks, in and on the road surface, indicated to me that this was where the stationary B trailer of truck 2 had been when it was struck by the prime mover of truck 3. The weight and momentum of truck 3 had shunted truck 2 forward and into the rear of truck 1*'.[17] D/A/Sergeant Frith further opined that '*the location of the marks, the direction of travel*

[15] Statement of Detective A/Sergeant Frith, Inquest Brief, pp629-630.
[16] Statement of Detective A/Sergeant Frith, Inquest Brief, p630.
[17] Statement of Detective A/Sergeant Frith, Inquest Brief, p631.

of the prime mover and trailers, post impact, damage to the cabin, and damage to the rear of the B trailer of truck 2, indicated to me that there had been a very late steering input to the right by the driver of truck 3. I was unable to identify any pre impact braking marks from this truck. The dual tyre scuff marks I identified, in the area of impact, appeared to have been left by the locked rear wheels of the B trailer of the truck 2'.[18]

26. In the opinion of D/A/Sergeant Frith '*from the level of damage to all the vehicles, it was evident to me that truck 3 had been travelling at speed when it impacted the stationary truck 2*'.[19]

27. The Major Collision Investigation Unit referred this matter to Detective Sergeant Hay, Collision Reconstruction and Mechanical Investigation Unit for the purposes of reconstructing the fatal collision. D/Sergeant Hay did not attend the collision scene however was supplied with all relevant material and following his analysis opined the following:

    a) '*The gouge marks are a good indication of the area of impact between two vehicles. Having reviewed the photographs from the collision scene with the vehicle in their rest positions and the salvage photographs there were no other gouge marks identified. From this I formed the opinion that this location was the area of impact between the two combinations. The location of the gouge marks indicates that the Kenworth combination was pushed approximately 28.5 metres by the Volvo combination post impact, given an assumed combination length of 25 metres and the rest position of the Kenworth combination*'.[20]

    b) '*I was provided with GPS tracking data from Star Track Express that shows the Volvo combination was travelling at approximately 98km/hr through Kaniva and approximately 1 minute later the sped was reported as 0 km/hr. Based on the lack of pre impact skidding and the fact that the rear end of the Volvo combination was approximately over the area of initial impact, it is my opinion that the Volvo combination was travelling at approximately 98km/hr when it ran into the rear of the Kenworth combination*'.[21]

[18] Statement of Detective A/Sergeant Frith, Inquest Brief, p631.
[19] Statement of Detective A/Sergeant Frith, Inquest Brief, p631.
[20] Statement of Detective Sergeant Hay, Inquest Brief, p639.
[21] Statement of Detective Sergeant Hay, Inquest Brief, p647.

c) '*It is my opinion that the Volvo driver did not apply the brakes on his combination prior to impacting the rear of the Kenworth combination'.*[22]

d) *'Based on the data supplied, the statements of NAIB and RODDA, the CCTV footage of the traffic queue and the scene evidence it is my opinion the Volvo combination was travelling at or close to 98km/hr, I am unable to comment on the accuracy of the supplied speeds … … when I take into account the UHF radio, the turning on of the rear hazards lights and the large number of vehicles queued, this collision should not have required an emergency response and should have been avoidable by an alert driver … … for an unknown reason the driver does not appear to have reacted to the queue of traffic stopped on the Western Highway. I am unable to explain why the driver failed to react to the stopped vehicles*'.[23]

28. On 4 March 2021 Senior Constable Giulieri, Mechanical Investigation Unit conducted a mechanical examination on the Volvo prime mover and the two trailers it was towing. Senior Constable Giulieri ultimately concluded that '*due to the extent of the damage caused by the fire many of the components could not be examined, however of the remaining components, my examination did not reveal any faults, failures or conditions that could have caused or contributed to the collision*'.[24]

29. The Coroner's Investigator at a later date enquired in respect of the license status of Steven, Ali NAIB and Robert RODDA with all three drivers appropriately licensed at the time with a multi combination endorsement to drive a heavy combination vehicle. D/A/Sergeant McCallum also made enquiries in respect of the registration status of all three prime movers and all six trailers involved in the collision and all were appropriately registered at the time of the collision.

30. During the course of the investigation, a Road Traffic Act (South Australia) blood sample was taken from Ali NAIB at the Bordertown Hospital, South Australia. Subsequent analysis of that sample detected no alcohol or illicit drugs to be present.

31. Robert RODDA participated in a Preliminary Breath Test whilst present at the collision scene that indicated a negative result to alcohol.

[22] Statement of Detective Sergeant Hay, Inquest Brief, p650.
[23] Statement of Detective Sergeant Hay, Inquest Brief, p655.
[24] Statement of Senior Constable Giulieri, Inquest Brief, p689.

Identity of the deceased

32. On 18 February 2021, Steven James LAWRIE, born 06 April 1974, was identified via DNA comparison (family reference sample provided by consent by a child of Steven's).

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

Medical cause of death

34. Forensic Pathology Registrar Dr Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 15 February 2021 and provided a written report of her findings dated 21 June 2021.

35. The post-mortem examination revealed extensive thermal injury with extensive fragmentation and charring, loss of the limbs and soft tissue/organ loss with soot and thermal effect in the trachea and main bronchi as well as severe double vessel coronary artery atherosclerosis (blocked coronary arteries). Dr Ho commented that coronary artery atherosclerosis predisposes a person to the development of cardiac arrhythmias and sudden death. In further correspondence Dr Ho indicated that '*the autopsy does show evidence of heart disease capable of causing him to pass out, but this does not mean he has necessarily had a heart attack*'.

36. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol, illicit drugs or carboxyhaemoglobin. Cyanide was detected at 1.6mg/L as was paracetamol. Dr Ho commented that carboxyhaemoglobin is a stable form of carbon monoxide that forms in red blood cells when carbon monoxide is inhaled. Carbon monoxide and cyanide are gases produced from the combustion of organic fuels and plastic products. In further correspondence Dr Ho confirmed that '*the presence of soot in the trachea and main bronchi would be in keeping with the deceased breathing at some point [after the fire had commenced]. The cyanide level detected would also be in keeping with this*'.

37. Dr Ho concluded that '*on the basis of the information available to me at this time and the described circumstances, the reason for the deceased's vehicle impacting into another stationary vehicle is not clear and cannot be unequivocally determined from autopsy. Given his degree of heart disease, it is possible the deceased sustained a cardiac arrhythmia, however, the described events are not entirely in keeping with this. Conversely, it is not possible for the autopsy to determine intent or if the deceased had fallen asleep at the wheel*'.

38. Dr Ho provided an opinion that the medical cause of death was 1 (a) EFFECTS OF FIRE IN THE SETTING OF A MOTOR VEHICLE INCIDENT (DRIVER).

39. I accept Dr Ho's opinion.

FURTHER INVESTIGATIONS REGARDING CAUSAL FACTORS OF COLLISION

VEHICLE MECHANICAL FAULT

40. Steven was driving a Volvo Prime Mover manufactured in 2013 and that had had its registration renewed on 30 June 2020. The speed-limiter compliance certificate was dated 23 July 2020 and the Prime Mover was last serviced on 21 January 2021. There were two trailers involved in the incident, M643 was last serviced in early December 2020 (within the 3-month scheduled service interval) and M563 was serviced on 1 February 2021, with major brake replacement occurring as part of that service.[25]

41. On 4 March 2021 Senior Constable Giulieri, Mechanical Investigation Unit conducted a mechanical examination on the Volvo prime mover and the two trailers it was towing. Senior Constable Giulieri ultimately concluded that '*due to the extent of the damage caused by the fire many of the components could not be examined, however of the remaining components, my examination did not reveal any faults, failures or conditions that could have caused or contributed to the collision*'.[26]

42. I find no evidence of mechanical fault or failure being a causal factor in the fatal collision.

DRIVER DISTRACTION DUE TO MOBILE PHONE USAGE

43. As part of the investigation, the Call Charge Records of Steven's mobile telephone including calls and SMS (Short Message Service) made from and/or to the mobile service number registered to Steven were obtained.

44. The final voice call registered to Steven's mobile phone occurred at 10.35pm (AEDT) or 10.05pm (ACDT) on 10 February 2021 when Steven's mobile phone contacted the number registered to hia parents. The voice call lasted for an hour and four minutes and after that telephone conversation, there is no record of any voice calls being made to or from that mobile phone prior to the fatal collision.

[25] Statement of Lindy Pascoe, Inquest Brief, p303.
[26] Statement of Senior Constable Giulieri, Inquest Brief, p689.

45. D/A/Sergeant McCallum opined that '*Call Charge Records (CCR) from Steven Lawrie's mobile phone show he was not involved in a phone call at the time of the collision. Data usage appears immense when comparing to phone call and SMS usage on Steven Lawrie's mobile phone*'.[27]

46. It is established that the first Triple Zero call received in respect of the fatal collision occurred at 2.21.47am (AEDT). It must be noted that Exhibit 17 appearing on p696 Inquest Brief should be interpreted with caution, particularly in respect of the TIME column given that that there is no relevant notation as to whether the time expressed is AEDT (Victoria) or ACDT (South Australia).

47. Having obtained the RCCRs from Telstra the raw dataset indicates that the most recent DATA usage proximate to the fatal collision occurred at 1.43.40am (ACDT) [converted to 2.13.40am AEDT]. The duration of this DATA usage was recorded as 642 seconds or 10min 42sec indicating that at the time of the fatal collision, Steven's mobile phone was being used in respect of DATA.

48. However, in correspondence with Telstra, they have advised that:

    a) With Steven's mobile phone having been destroyed by fire in the fatal collision, it is *not* possible to identify the apps, website or activity relevant to this DATA download

    b) A 'DATA' download needs to be interpreted with caution in that it can represent either

        i. an active input by the user (ie. the person in possession of the mobile device has to actively perform an action on the device resulting in the data download); or

        ii. a background or passive download, in the absence of any user input, for example an app update

49. Telstra have confirmed that it is *not* possible to distinguish between an active user input or a background/passive download.

[27] Statement of Detective A/Sergeant Lucilla McCallum, Inquest Brief, p691H.

50. Whilst the RCCRs of Steven's mobile phone indicate that it was utilising DATA at the time of the fatal collision, for the reasons outlined above, I am unable to find, to the requisite standard, that Steven was using and subsequently distracted by his mobile phone at the time.

DRIVER FATIGUE

51. Numerous people who knew Steve very well, expressed concerns in respect of fatigue being a causal factor of the collision. Margaret Lawrie, Steve's ex-wife expressed in her statement that '*when I found out that he was driving trucks, I said "He should never drive a truck because he will either kill himself or kill someone because he can't stay awake … … he just can't stay awake … … he just nods off"*'.[28] Hamish Lawrie expressed concerns saying '*his sleep was very on and off … … he wasn't the best at, like, getting consistent and good sleep … … I don't think he was probably suitable to be driving trucks 'cause whenever he seemed to have longer trips he struggled*'.[29]

52. Leonie Fitzgerald gave evidence that '*when we broke up and Steve moved into the lodge the drinking became more excessive … … he would drink 3 to 4 beers or quarter or more of a bottle of Captain Morgan Rum straight as his "sleep aid" and then go to work after dozing. He wasn't sleeping though because you could see he was awake and active on Facebook all day. I raised my concerns around fatigue and driving with Steve, but he dismissed everything I said or suggested, and told him on numerous occasions to go to bed and sleep properly*'.[30]

53. Colin Wardrop gave evidence that '*generally, Steven would get home around 8.30-900am the following morning. He would regularly bring home beers and would sit on the couch in the main house and drink until after midday. Instead of going to bed for a proper sleep, he would doze on the couch until he left for work. I never really thought he was getting proper rest for the driving he was doing. The only time he would go to bed would be when Leonie was also in bed after she did a night-shift. Leonie's work times were pretty varied, but she didn't do night shifts all that often*'.[31]

54. Robert Dalton gave evidence that '*Lawrie was having trouble sleeping during the day and the drive from Wingfield and Gawler both ways was adding to his driving time. Lawrie had told me he was tired and getting about 3 to 4 hours of sleep a day. He was doing the NHILL changeover 5 times a week. The hours of work was between 7.00pm and 6.00am-7.00am the*

[28] Interview of Margaret Lawrie, Inquest Brief, pp151-152.
[29] Interview of Hamish Lawrie, Inquest Brief, pp204-205 & p208.
[30] Statement of Leonie Fitzgerald, Inquest Brief, pp217-218.
[31] Statement of Colin Wardrop, Inquest Brief, p225.

next morning'.[32] On Wednesday 10 February Robert Dalton recalled Steven having about 3 to 4 hours of sleep, '*I heard him come home in the morning at about 7 to 8am. I saw him have 2 or 3 spiced rum and about 3 or 4 beers. The spiced rum were pour your own and more generous than a standard drink. I think he would have gone to bed at about 2 o'clock in the afternoon. I reckon he woke up about 6.00pm or there about. He got his Farmers Union milk from the fridge and went to work. That was the last time I saw him*'.[33]

55. In contrast, Peter Simmons gives evidence that Steven '*never mentioned that he was tired or fatigued. I would speak to him about 2 to 3 times a week at about 6am when I was on my way to the office. Sometime he was still coming in at this time or just dropping off the trailers. We would chat briefly about how the night had gone*'.[34]

56. The Coroner's Investigator, using Steven's '*work diary pages, Call Charge Records and Safe-T-Cam detections involving Steven Lawrie/the Volvo prime mover compiled a fatigue interrogation timeline concerning Steven Lawrie's movements and actions from Tuesday 2 February 2021 to Thursday 11 February 2021*'.[35] Following this analysis Detective A/Sergeant McCallum opined that '*an examination into Steven Lawrie's movements over the nine days prior to the collision … … shows Steven Lawrie's sleeping patterns leading up to the collision were interrupted and fragmented*'.[36,37]

57. The Volvo Prime Mover being driven by Steven at the time of the collision was fitted with a Guardian System manufactured by Seeing Machines Limited. The Guardian is a '*Driver Monitoring System (DMS) which monitors driver/operator attention and can identify drowsiness and distraction across multiple transport sections … … Guardian works in real-time, using advanced in-cab sensors and sophisticated face tracking algorithms to track a driver's eyelid and head position to detect driver fatigue and distraction, providing real-time in-cab intervention to the driver*'.[38] Guardian captures a range of classified events including 'fatigue events', 'distraction events', 'field of view events' and 'manual recording events'. When an event is detected, the Guardian system alerts the driver via an audible alarm and a seat vibration. Concurrently, information regarding the event is sent via 3G communications to a Guardian Live database.

[32] Statement of Robert Dalton, Inquest Brief, p237.
[33] Statement of Robert Dalton, Inquest Brief, p239.
[34] Statement of Peter Simmons, Inquest Brief, p254.
[35] Statement of Detective A/Sergeant Lucilla McCallum, Inquest Brief, p691H.
[36] Statement of Detective A/Sergeant Lucilla McCallum, Inquest Brief, p691I.
[37] Exhibit 18, Fatigue Interrogation Timeline, Inquest Brief, pp697-706.
[38] Statement of Max Verberne, Inquest Brief, p306.

58. According to a statement provided by Seeing Machines in respect of the Guardian system installed within Steven's Prime Mover that evening, '*the transmission and details of the heartbeat data suggests that all aspects of the Guardian unit installed in the vehicle in question was operating correctly on 11 February 2021*'.[39] Heartbeat data was transmitted throughout the vehicle's entire journey that evening, the final heartbeat data transmission occurred at 1.39am (ACDT) [converts to 2.09am (AEDT)].

59. Investigations revealed that there were twenty-one (21) event activations in relation to vehicles driven by Steven between 28 January 2021 and 11 February 2021. Of these twenty-one events that were detected, only two (2) were verified and confirmed as follows:[40]

    a) On Tuesday 9 February 2021 there was a Guardian event at 1.54am that was an attention off road, notifiable distracted driving confirmation.

    b) On Tuesday 9 February 2021 a Guardian incident occurred at 4.48am that was a drowsiness confirmed fatigue incident. Analysis of the video showed that Steven closed his eyes and appeared to fall asleep at the wheel of the truck before the Guardian System alerted him. In response to that incident Peter Simmons, Managing Director indicated that '*I received an email from Guardian notifying me of a fatigue incident. I am not sure if I received a telephone call or not to report it. I can't remember if I spoke to Lawrie about it or not*'.[41]

60. There is no record of any event, however classified, being transmitted to the Guardian Live database around the time of the collision. The last logged event on the Guardian Live database occurred at 12.46.42am (ACDT) [converts to 1.16.42am (AEDT)] and was a distraction event. The RCCRs were obtained from Telstra in respect of the SIM card contained within the Guardian unit installed within Steven's Prime Mover. These records show that the last recorded data transmission over the GPRS 3G network occurred at 1.44.35am (ACDT) [converts to 2.14.35am (AEDT)], approximately 7 minutes prior to the fatal collision.

61. Consideration must then be given to the question as to whether the Guardian system commenced recording either a 'fatigue event' or a 'distraction event', causal to the collision, however that event was never transmitted. Information sought during the investigation from both Telstra and Seeing Machines Limited gathered the following highly relevant information:

[39] Statement of Max Verberne, Inquest Brief, p307.
[40] Affidavit of Senior Constable Sarvas, South Australia Police, Inquest Brief, pp573-574.
[41] Statement of Peter Simmons, Inquest Brief, p255.

a) The transmission of data by the Guardian relies on the 3G network of the telecommunications provider detected in the area in which the Guardian unit is located.

b) Telstra confirmed that at approximately 2.20am AEDT there were no known issues with the relevant mobile tower site (Wolseley 3G) and that on all available evidence the Telstra 3G network was operating and available at that site of the fatal collision.

c) The Guardian system does not have its own battery. It is powered by direct connection to the vehicle's ignition. As such, if the vehicle is in a collision that compromises the vehicle ignition causing power supply to the Guardian to be cut off, the unit will no longer be operational.

d) Duration of actual events varies depending on the length of time of the event. Each event includes 2 seconds of padding before and after the event for an additional 4 seconds. The minimum duration of a fatigue event would be 5.5 seconds whilst the minimum duration of a distraction event would be 8 seconds.

e) Following an event detection, the event is recorded as a whole to the Guardian system located within the truck in the first instance. Upon conclusion of the recording, data transmission commences. The transmission time of data by the Guardian is dependent on the strength of the 3G network and the volume of data being transmitted. For the avoidance of doubt, the Guardian system does not 'live stream' to the Guardian Live database.

62. The absence of a detected event is not in and of itself irrefutable evidence of either a fatigue or distraction occurrence within the Prime Mover cabin proximate to the fatal collision. The absence of a detected event may also be explained by a number of variables, including that an event was still being detected or recorded, and/or that the subsequent collision has compromised the power supply to the Guardian unit, fatally compromising any subsequent transmission over the 3G network.

63. The absence of a detected event however *does not* allow me, to make a finding, to the requisite standard of proof, that either a fatigue or distraction event has occurred immediately prior to the collision and therefore causally contributed to it. Considering all the available evidence, there is *insufficient* evidence to make a finding that a fatigue event (Steven falling asleep at the wheel) occurred.

DRIVER MEDICAL EPISODE

64. I refer to the medical cause of death and the autopsy findings of Dr Ho discussed previously at [34]-[38]. The autopsy revealed that Steven was suffering from severe double vessel coronary artery atherosclerosis (blocked coronary arteries) that predisposes a person to the development of cardiac arrhythmias and sudden death. The toxicological analysis supports a conclusion that Steven was breathing at least during the initial stages of fire development, post-collision. Further I note Dr Ho's comments '*given his degree of heart disease, it is possible the deceased sustained a cardiac arrhythmia, however, the described events are not entirely in keeping with this*'.

65. On the basis of all the available evidence, I find to the requisite standard, that there is *insufficient evidence* to support a finding that Steven suffered a cardiac arrhythmia (or other medical episode) resulting in the fatal collision.

DRIVER | INTENTIONAL ACT | SUICIDE

66. Forensic analysis of the collision scene determined that at the time of impact Steven was driving his Volvo prime mover and B-Double combination at or close to 98km/hr with no evidence of braking prior to impact. In those circumstances it necessarily raises for consideration the difficult question as to whether the collision was an intentional act by Steven to suicide. In evaluating this there is a need to consider Steven's family history and family circumstances proximate to the collision.

67. Steven was born to Alan and Rosie Lawrie in 1974 and was the older brother to Paula who was born two years later. At the age of 20 Steve met his then-to-be wife, Margaret Lawrie at a rodeo and they were engaged on Margaret's twenty-first birthday and were subsequently married. Three children were born from this marriage, two daughters and a son.

68. Margaret described a relationship where '*I sort of realised I was controlled quite a bit in the relationship*'.[42] Asher Lawrie, the eldest daughter described that '*growing up was like we were always walking on eggshells; we would always just stay in our rooms because we didn't want to be near him*'.[43] Hamish Lawrie described that '*growing up he probably wasn't the nicest person … … he's always so generous with other people and then when he's at home he's just a grumpy old man'*.[44]

[42] Interview of Margaret Lawrie, Inquest Brief, p97.
[43] Statement of Asher Lawrie, Inquest Brief, p162.
[44] Interview of Hamish Lawrie, Inquest Brief, p168 & p190.

69. Both Asher and Hamish Lawrie summed up the complexity of the familial relationships, Asher in saying '*now that he is gone, I don't know how to feel, it's hard because people message me and tell me how much of a good guy and a hero my dad is but that is not the person I knew*'[45] whilst Hamish expressed '*I think that it's very mixed, there's some really good things, like, that I had with him but then there's also some really bad things, so it's very mixed*'.[46]

70. Margaret and Steven's marriage deteriorated significantly from October 2017 with Margaret describing incidents of physical and sexual violence towards her.[47] In August 2018 their relationship irretrievably broke down and Steven permanently moved out and into a caravan that was located on his then employer's property.

71. In October 2018 Steven met Leonie Fitzgerald through a singles group on Facebook. They commenced a relationship in early November 2018 that continued up until the middle of November 2021. At the start of their relationship Steven was employed as a trade assistant for Yates Electrical that required him to work at the company yard and to travel to assist in the installation of solar panels at solar farms. In May 2020 Leonie and Steven moved into 'The Lodge', a self-contained unit on the property of Colin Wardrop in Gawler.

72. At the onset of the COVID-19 pandemic Steven lost his employment with Yates Electrical and became unemployed and in Leonie's opinion '*from here on he no longer worked away and it became a struggle to get him to look for and apply for jobs*'.[48] Through one of Leonie's friends, enquiries were made with Allan Miller Transport and Steven was invited to attend for an informal interview with their Operations Manager following which he was offered a traineeship. He commenced with Allan Miller Transport Training on 10 July 2020 training for a Certificate 3 Traineeship in Driving Operations as a novice MC driver predominantly for interstate driving.

73. In November 2020 Leonie ended their relationship as she was '*over Steve's aggressive verbal outbursts, his controlling, demeaning and degrading behaviour all because of me not meeting his perceived needs for him to be satisfied*'.[49] Whilst Steven remained living for the time on Colin Wardrop's property, it was in a premises separate to that of Leonie.

[45] Statement of Asher Lawrie, Inquest Brief, p167.
[46] Interview of Hamish Lawrie, Inquest Brief, p211.
[47] Interview of Margaret Lawrie, Inquest Brief, pp110-113.
[48] Statement of Leonie Fitzgerald, Inquest Brief, p215.
[49] Statement of Leonie Fitzgerald, Inquest Brief, p217.

74. On Monday 23 and 30 November 2020, Steven attended Springwood Family Medical, Gawler East and had appointments with GP Dr Zirapuri where he raised concerns in respect of his mental health. Doctor Zirapuri referred Steven to Principal Clinical Psychologist Deidre Steadman-O'Dea at Alpha Psychology, Gawler however there is no record of Steven making contact with Alpha Psychology.[50] A search of Steven's PBS records in the two years prior to his passing also shows no evidence of him being prescribed or taking antidepressant medication.

75. In December 2020 Steven met Pauline Christie on the online dating app Tinder. Initially they communicated via text messages in the app and then they met for a drink at the Golden Fleece Hotel in Gawler on 27 December 2020. In Pauline's opinion during this meeting '*Steven adored his children and he was so proud of them. He was really upset that his two daughters didn't communicate with him at all. I believe he was still talking with his son Hamish who called him all the time. During my conversations with Steven, he never came across as depressed at all. He did at times dwell on things from his past but I tried to get him to stay positive and look forward to things in the future*'.[51] The next time they met up was on 22 January 2021 at a coffee shop in Salisbury and '*during this date Steven seemed really upbeat and positive. He was smiling the whole time. I remember he said something like "I'm taking a leaf out of your book and I'm not worrying about the things that I don't have control over*'.[52]

76. On Tuesday 2 February 2021 Leonie attended Gawler Police Station and made a complaint in respect of Steven following which an affidavit was taken by Senior Constable First Class (SC1C) Walker and subsequently signed by Leonie. A signed affidavit was also provided by Leonie's daughter, Tamara Brown who had witnessed the alleged incident. Leonie alleged that on Sunday 31 January she had been at her home address when a verbal argument had significantly escalated and Steven had grabbed her by the shoulders before shoving her backwards.[53] Leonie stated in her affidavit '*I felt physically unwell after what had happened and ended up vomiting and crying until I fell asleep. I am afraid of Steven and what he is capable of when he is having a violent outburst, which is why we broke up in November. I didn't have any soreness or bruising after he grabbed me, but the fear of it all is what really got to me*'.

[50] Exhibit 25, Correspondence from Alpha Psychology, Inquest Brief, p742.
[51] Statement of Pauline Christie, Inquest Brief, p221.
[52] Statement of Pauline Christie, Inquest Brief, p222.
[53] Affidavit of Leonie Fitzgerald, Inquest Brief, pp717-720.

77. At the same time SC1C Walker completed a domestic abuse victim risk assessment in relation to Leonie that was subsequently assessed as 'standard'. This means that Leonie had been provided with all relevant information in respect to SAPOL processes including explaining bail and Police Interim Intervention Orders conditions as well as information and advice being provided in respect of home and personal security. It was further confirmed that Leonie had a number of supports in place and that there were no identified risks that would require an escalation of SAPOL response at this point in time.

78. The following day, Wednesday 3 February, Constable Cleary and Senior Constable Maney were on uniform mobile patrol when they were made aware of the allegations of domestic assault reported the previous day by Leonie. They attended Steven's address in company with Sergeant Walker and knocked on the front door of an outbuilding that was subsequently answered by Steven. Following a brief interaction recorded on Constable Cleary's Body Worn Camera, Steven was placed under arrest for assault and conveyed to the Elizabeth Cells for charging. In Constable Cleary's opinion '*LAWRIE was calm and compliant and did not appear to be emotionally upset about his arrest*'.[54] Steven was interviewed in respect of the allegations and denied ever assaulting Leonie however conceded there had been a verbal but not physical escalation.

79. Constable Cleary subsequently completed paperwork in respect of a Police Interim Intervention Order (PIIO)[55] that was subsequently served on Steven whilst he was in custody. Upon service of the PIIO, Constable Cleary indicated Steven '*became emotional and started to cry*'.[56] The terms of the PIIO required Steven to vacate his current premises for the safety of Leonie and her daughter. In Constable Cleary's opinion '*LAWRIE was emotional at the Elizabeth Cells regarding the breakdown of his relationship and the condition of his PIIO however he did not make any threats of self-harm … … LAWRIE appeared focused on being granted bail so that he could continue his work as a truck driver*'.[57] On agreeing to the terms of his bail, and being served the PIIO, Steven was returned to his previous address to collect some personal belongings and his vehicle before leaving the property.

[54] Affidavit of Constable David Cleary, South Australia Police, Inquest Brief, p589.
[55] Exhibit 23, Interim Intervention Order, Inquest Brief, pp721-723.
[56] Affidavit of Constable David Cleary, South Australia Police, Inquest Brief, p590.
[57] Affidavit of Constable David Cleary, South Australia Police, Inquest Brief, p590.

80. Following his release on bail, Steven temporarily stayed at Robert Dalton's premises in Parafield Gardens prior to his passing. Robert gives evidence that '*he lived with me for about 8 days from the time he was arrested until the time that he died in the collision on the Western Highway. I would describe his demeanour during that time with me as varied. He was sad and angry because the relationship with Fitzgerald was over. He wasn't sleeping particularly well. I noticed him getting about 4 to 5 hours of sleep a day in the week leading up to the crash whilst he was living at my house. He could have even had less than that amount of sleep*'.

81. Alan Lawrie, Steven's father last saw Steve on 4 February 2021 following the breakdown of his relationship with Leonie. In Alan's opinion '*Steve was bright and cheery and happy that day. We didn't speak about anything in particular, just getting the caravan organised and helping clean up the yard*'.[58] In respect of his employment Alan was of the opinion that '*Steve got on well with all the guys he worked with. He was happy working there and wanted to stay on. Allan Millar was looking at getting another run, which was to be a daytime run to Roxby Downs. Steve was supposed to be moving across to this run when it started, which he was looking forward to*'.[59] Alan also noted Steve was very proud of his three children as they were either attending university or had obtained full-time employment.[60]

82. On Wednesday 10 February Robert Dalton recalled Steven having about 3 to 4 hours of sleep, '*I heard him come home in the morning at about 7 to 8am. I saw him have 2 or 3 spiced rum and about 3 or 4 beers. The spiced rum were pour your own and more generous than a standard drink. I think he would have gone to bed at about 2 o'clock in the afternoon. I reckon he woke up about 6.00pm or there about. He got his Farmers Union milk from the fridge and went to work. That was the last time I saw him*'.[61]

83. On Wednesday 10 February Pauline Christie and Steven were messaging back and forth. According to Pauline '*it was evening and he was starting his shift. Steven said he had to go as his trailer was ready but he asked if I wanted to catch up with him for lunch on Friday 12 February. I said that I did and he replied "let me surprise you, gotta go, catch ya, speak soon* 😊*". That was the last message I ever received from Steven*'.[62]

[58] Statement of Alan Lawrie, Inquest Brief, p89.
[59] Statement of Alan Lawrie, Inquest Brief, p88.
[60] Statement of Alan Lawrie, Inquest Brief, p89.
[61] Statement of Robert Dalton, Inquest Brief, p239.
[62] Statement of Pauline Christie, Inquest Brief, p222.

84. Alan and Rosie Lawrie last spoke with Steven on the phone that night of the incident. It was habit that every day when Steven was driving his parents would call him, usually around 10pm and talk for about an hour. On this final occasion Alan was of the opinion that '*there was nothing that stood out about the call. We were just talking in general as usual and he seemed quite happy. He mentioned that his changeover driver was running about half an hour late so he was going to have a snooze before he swapped the trucks over*'.[63] After Steven's passing, no correspondence was located within his personal belongings indicative of any form of suicidal ideation or intent.

85. The driver, Gaganpreet Guraya, whom Steven exchanged trailers with at Nhill prior to the fatal collision gives evidence that '*we hooked up the trailers and checked the trailers. After that I was tired and I took a power nap of about half an hour. After about five minutes, Steven left. I think he left at about 1:40-1:45, something like that. I would normally have a chat with him for about five to seven minutes when we swapped over the paperwork, but I was tired this night so I was not feeling like a chat. Because we did not have a chat that night I can't say whether he was ok or not*'.[64]

86. Following the fatal truck collision and Police notification to Margaret Lawrie, correspondence occurred between Margaret and Leone Fitzgerald during which Leonie '*said to her [Margaret] I think he's killed himself and she agreed. We then continued our conversation in relation to suspicion of intent where she disclosed that Steve always threatened suicide to her, and I disclosed that he had done the same to me on numerous occasions*'.[65]

87. Colin Wardrop upon being notified of Steven's death indicated that '*my first thoughts after I learned that Steven had been killed in the crash was, "He hasn't got the kahuna's to kill himself". Like everyone else, I've done a lot of reflecting since and believe it is more than possible that Steven did deliberately drive into the truck to kill himself. I know that Steven was petrified of going inside (to jail) because of the incident with Leonie and the other AVO's. He was fixated on not wanting to go to jail and no amount of me explaining the court system to him was getting through. He continued to deny his actions and taking responsibility for his actions and words*'.[66]

[63] Statement of Alan Lawrie, Inquest Brief, p89.
[64] Statement of Gaganpreet Guraya, Inquest Brief, p262.
[65] Statement of Leonie Fitzgerald, Inquest Brief, p219.
[66] Statement of Colin Wardrop, Inquest Brief, p227.

88. On the available evidence it is indisputable that at the time of his passing, Steven was experiencing significant challenges within his personal life, in particular the breakup of his relationship with Leonie and subsequent charges and Police Interim Intervention Order. However I also note the evidence of Steven's parents and the final telephone call that they had with him that evening, as well as his recent messages with Pauline Christie. Having considered all of the circumstances, I find to the requisite standard, that Steven did not intentionally take his own life and that suicide was not a causal factor in the fatal collision.

SOUTH AUSTRALIA-VICTORIA BORDER VEHICLE CHECKPOINT

89. The collision scene was located on the Western Highway, Serviceton, approximately 6.7 kilometres from the South Australian border, on the Victorian side.[67]

90. On 5 February 2021 border checking stations (or border checkpoints) were reactivated by South Australia Police on the Victoria/South Australia border, following reports the previous day of an outbreak of COVID-19 from Hotel Quarantine in Victoria. The *Emergency Management (Cross Border Travel No 34) (COVID-19)* Direction 2021 (under section 25 of the *Emergency Management Act 2004* (SA)) (**Direction #34**) was made on 4 February 2021 at 6.16pm and had operated from that time. This introduced quarantine and testing requirements for relevant Victorian arrivals but did not prohibit their entry into South Australia.[68,69]

91. The border checkpoints on the Victoria/South Australia border were reactivated on 5 February 2021 in order to assess incoming travellers, process their arrival into South Australia and enforce the quarantine and testing requirements of Direction #34. The only persons who would be prohibited from entering South Australia at these checkpoints were those who had been in the relevant areas of Western Australia in the relevant preceding period. The assessment and processing of incoming travellers was undertaken by SAPOL personnel utilising the electronic Cross Border Travel Registration system (the CBTR system) that was an automated system that would, depending on the responses provided, automatically approve, decline or accept the application for manual assessment by SAPOL. The role and function of border personnel deployed to border checkpoints was to process travellers by way of the CBTR system; either by simply cross-referencing automatically approved or already-assessed applications or by assessing unassessed applications again the relevant Direction.[70]

[67] Statement of Sergeant Wright, Inquest Brief, p624.
[68] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p311.
[69] *Emergency Management (Cross Border Travel No 34) (COVID-19)* Direction 2021, Inquest Brief, pp338-362.
[70] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp311-312.

92. Direction #35[71] had no consequential impact on the Victoria/South Australia border aside from continuing the operation of the Serviceton checkpoint which had been reactivated and was operational from 5 February 2021 onwards as a result of Direction #34.

93. At 12.01am on 11 February 2021, *Emergency Management (Cross Border Travel No 36) (COVID-19) Direction 2021* (under section 25 of the *Emergency Management Act* 2004 (SA)) (**Direction #36**)[72] came into force. This direction was made in response to the worsening COVID-19 situation in Victoria and prohibited entry to any person who:

a) had been in Greater Melbourne on or after 12.01am on 4 February 2021; or
b) had been at the Melbourne Airport Holiday Inn on or after 12.01am on 27 January 2021; or
c) was a close contact of a person mentioned in paragraph (b).

The only exception were "*essential travellers*" and certain other exempted categories of people defined in the Direction #36 border closure. The Serviceton checkpoint, already operational and reactivated from 5 February 2021, transitioned immediately to this 'hard' border closure as at 12.01am on 11 February 2021.[73] There was no physical change to the border checkpoint upon the transition to the Direction 36 border closure and the TGS continued to operate in the same form. The processing approach at the border also did not change as all travellers would continue to be stopped and assessed as to the application of appropriate restrictions upon their entry into South Australia.[74]

94. Assistant Commissioner Patterson indicates in his statement that '*there was no direct communication from the Commissioner of South Australia Police to the Victorian Government with respect to the Direction 36 border closure and associated arrangements. The Commissioner's communication regarding this issue was carried out through public messaging*'. Assistant Commissioner Patterson also indicated that '*there existed no formal SAPOL process which mandated notification to Victoria Police of any changes to border operations that may affect traffic flow … … As a result there was no direct communication from the Border Commander to Victoria Police with respect to the Direction 36 border closure and associated arrangements*'.[75]

[71] *Emergency Management (Cross Border Travel No 35) (COVID-19)* Direction 2021, Inquest Brief, pp363-385.
[72] *Emergency Management (Cross Border Travel No 36) (COVID-19)* Direction 2021, Inquest Brief, pp387-410.
[73] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp312-313.
[74] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p316.
[75] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p317.

95. SAPOL relied upon media engagement and associated communication strategies to communicate the border closure to the general public in Victoria. Approximately 3.41pm on 10 February 2021 it was announced by the SAPOL Commissioner at a media conference with the Chief Public Health Officer that it was intended that Direction #35 would be revoked and replaced from midnight that night by Direction #36. The public was informed that the final decision was to be made pending further SA Health advice. '*This announcement by the Commissioner was live streamed by all television stations and was tweeted by a number of journalists, news outlets and government agencies (including those in Victoria) shortly afterwards*'.[76] SAPOL communicated the new Direction through a variety of means including online publishing (COVID-19.sa.gov.au website), social media announcements (Facebook, Twitter and Instagram) and media releases that were automatically sent to subscribers that included all local media outlets as well as regional media. At 9.03pm on 10 February 2021, a SAPOL Facebook post and tweet was released confirming the Direction 36 border closure followed immediately thereafter by a media release advising the terms of Direction 36, specifically those who could/could not enter South Australia. At approximately 11.31pm the signed Direction #36 was published on the website.

96. Assistant Commissioner Patterson indicates that '*there was no direct communication from the Commissioner of SAPOL with National Heavy Vehicle truck drivers regarding the Direction 36 border closure. I am also not aware of any direct communication between DIT or Altus with National Heavy Vehicle truck drivers*'.[77] The public messaging detailed in the paragraph above was relied upon to inform both the general public and truck drivers in respect of the Direction 36 border closure.

97. From the statement of Assistant Commissioner Patterson it has been possible to reconstruct the timeline detailed within Appendix A regarding the setup, establishment and operation of the border checkpoint.

98. A number of truck drivers either involved in the collision itself, or who were stationary in the traffic line-up at the Victoria-South Australia border provided statements that give evidence in respect of their own knowledge of the border closure and subsequent effect on traffic that evening.

[76] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p319.
[77] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p320.

99. Marcus Vonzieden, a self-employed truck driver driving a Volvo B-Double combination gave evidence that hours preceding the fatal collision, '*I crossed the SA border into VIC at about 9.20pm. When I crossed the border there were no restrictions in place and no indication that there was going to be*'.[78] Marcus indicated that as he was travelling through Kaniva he heard over the UHF that there was a line-up of traffic at the border. In Marcus' opinion '*there were no warnings leading up to the border to alert people to the closure and traffic build up*'.[79] He also notes that '*the only way drivers can notify or get alerted to hazards on the road is via the UHF radio. In SA we have an application called SA ALERTS which sends alerts to phones to notify of fires and other emergencies and hazards. I believe an app that does the same but for Border Closures and other major road hazards would help drivers out tremendously in planning ahead and being safe*'.[80]

100. Ali Raza Naib who was driving the B-Double combination for Tremco Bulk Transport Pty Ltd and whom was directly impacted by Steven's truck gives evidence that since May 2020 he would be travelling weekly through interstate vehicle checkpoints (VCPs) to cross borders between Victoria, South Australia and Western Australia as an interstate truck driver. Ali indicates that '*due to our travelling schedule we would usually always travel through the Serviceton VCP at night. I remember each time I would approach the VCP in Serviceton there would be a sign on the side of the road saying 'Police checkpoint ahead' in addition to an 80km/h speed sign … … this was set up approximately 1km before the VCP. Approximately 100 metres before the VCP there would be a second sign saying 'Police checkpoint ahead' in addition to an 25km/h speed sign. At the time of the crash I didn't see any of these warning signs due to the amount of traffic backed up … … whilst operating as an interstate truck driver during the pandemic I was very aware of the VCP's and would regularly receive updates from my supervisor regarding any changes to travel restrictions prior to departing Western Australia. In addition, I would monitor the news and online sources for any changes in travel restrictions*'.[81]

[78] Statement of Marcus Vonzieden, Inquest Brief, p265.
[79] Statement of Marcus Vonzieden, Inquest Brief, p266.
[80] Statement of Marcus Vonzieden, Inquest Brief, p267.
[81] Statement of Ali Raza Naib, Inquest Brief, pp279-282.

101. Kevin Woodward who was driving in tandem with Ali Raza Naib but who was asleep in the cabin bunk at the time of the collision, gives evidence that '*I was previously aware of the Bordertown VCP however it had not been in place during my previous journeys that I can recall. I have not been through any other temporary VCPs until the one we approached at Bordertown on the night of the crash*'.[82]

102. Robert Rodda who was driving the B-Double combination impacted by that of Ali Raza Naib's, indicated that he was aware of the long line-up of traffic at the border crossing from listening to the UHF radio channel, including that '*I was told over the UHF radio the line-up was about 6 kilometres long and the traffic was at a stop*'.

103. The section of the Western Highway, Serviceton where the fatal collision occurred was subject to oversight by the Director, Grampians Region, Victorian Department of Transport, a position held by Michael Bailey at the time. Mr Bailey indicated in his statement that '*following the South Australian Government's decision, I was not formally notified of the establishment of the border checkpoint from either the Department of Transport emergency management team or SAPol directly. I found out about the SA border closure around 5am on 11 February 2021 after I was contacted about the collision*'.[83]

    a) Mr Bailey explained that typically the Region would be contacted through the State Control Centre for Emergency Management. In the circumstances that existed the evening of the fatal collision, Mr Bailey understood that South Australia held responsibility for border checkpoints and subsequent traffic management as the State initiating the border closure.

    b) The notifications and response were dependent on which state is instigating the border restriction (in circumstances where Victoria closed its borders to South Australia, the control agency would be Victoria Police, and the Department of Transport would operate in support of the control agency and assume responsibility for establishing all traffic management checkpoints and the messaging for travellers).[84]

[82] Statement of Kevin Woodward, Inquest Brief, p289.
[83] Statement of Michael Bailey, Inquest Brief, p297.
[84] Statement of Michael Bailey, Inquest Brief, p297.

104. Sergeant Darren Wright, Station Commander of the Kaniva Police Station indicated in his statement that '*the South Australian border with Victoria on the Western Highway is approximately 439 kilometres northwest of Melbourne and 290 kilometres south east of Adelaide. The Kaniva township is located approximately 26 kilometres east of this border. The Kaniva Police Response Zone (RZ) includes approximately 49kms of the Western Highway from Lawloit, west to the South Australian border at Serviceton. Although a continuation of the same stretch of road, the Western Highway becomes the Dukes Highway upon crossing the border into South Australia*'.[85]

105. Sergeant Wright indicates that '*South Australian Police (SAPOL) checkpoints have been operational for substantial periods between March 2020 and February 2021, in varying capacities as determined by the SAPOL Command and the South Australian Government … … over that eleven (11) month period, the only source of information relating to South Australian border checkpoint restrictions was self-generated through news media announcements, public websites and information received from the local community … … I don't recall receiving any internal notifications regarding SAPOL border checkpoint operations*'.[86]

106. Sergeant Wright received no notification in relation to any changes to SAPOL checkpoint operations or barriers to entry during Wednesday 10 February 2021.[87]

107. The SAPOL Commissioner had overall responsibility for the establishment of, control and subsequent management at the Victoria/South Australia border checkpoint at Serviceton. The Serviceton checkpoint was reactivated and installed on 5 February 2021, in accordance with the Traffic Guidance Systems (TGS) devised by contracted traffic management provider Altus Traffic on behalf of the South Australian Department for Infrastructure and Transport (DIT). The Serviceton checkpoint plan was developed in accordance with the requirements outlined in *Australian Standard – AS1742.3* and the *Road Management Act 2004* (Vic). A Variable Messaging Sign (VMS) was situated approximately 1.3 kilometres east of the border (near Serviceton Road North) on the Western Highway to support the TGS, with the alternate messaging 'SA BORDER CONTROL' and 'ROAD CLOSED AHEAD'.[88]

[85] Statement of Sergeant Wright, Inquest Brief, p592.
[86] Statement of Sergeant Wright, Inquest Brief, pp594, 596 & 597.
[87] Statement of Sergeant Wright, Inquest Brief, p597.
[88] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp314-315.

108. Assistant Commissioner Patterson indicates that '*at the time of the border closure on 11 February 2021 there were no mechanisms implemented to warn approaching traffic specifically of the stationary backlog. The general mechanisms to slow approaching vehicles down and alert them to the need to stop at the Serviceton checkpoint were the TGS and associated VMS, although the queue of traffic at the time of the collision extended beyond the VMS supporting and warning of the TGS which was located approximately 1.3km from the border. The border restrictions that arose in response to the COVID-19 pandemic were (and continue to be) necessarily fast moving and rapidly changing situations which have to be responded to with the different measures required by the various outbreaks. In response to the decision to 'close' the border SAPOL had to deal with a significant backlog that exceeded the volume of traffic anticipated in a remote location*'.[89]

109. However Assistant Commissioner Patterson conceded that '*the relevant warning mechanisms deployed as part of the TGS did not change as a result of the growing traffic backlog. SAPOL had limited personnel at the Serviceton checkpoint over the night shift who all worked at maximum capacity. Further, the police personnel on hand initially were not aware of the full extent of the backlog*'.

110. Indicative traffic flows at road entry points into South Australia highlighted that the Dukes Highway from Victoria is the State's busiest road entry point (ie. the Serviceton checkpoint). The level of staffing over the night shift of 10/11 February 2021, that is three personnel, was normal for night shift duties at the Serviceton checkpoint. Night shift ordinarily commenced at 7.00pm and concluded at 7.00am the following day. Seven personnel worked each day shift, with two additional SES personnel having recently been deployed to the day shift to ensure sufficiency of resources. No ADF personnel were present at the Serviceton checkpoint during this period and no SES personnel were rostered to the night shift. In addition to the rostered staff, two additional members, Constable Do and Senior Constable First Class Finlay were deployed in the early hours of 11 February 2021 to assist the night shift specifically due to SAPOL becoming aware of the extent of the backlog of vehicles.[90]

[89] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p333.
[90] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp328-329.

111. Assistant Commissioner Patterson submitted in his statement '*There are practical obstacles that make it impossible for SAPOL to surge greater levels of staff quickly to remote sites such as the lack of available local resources to supplement border checking station personnel, along with the distance from the metropolitan area and the time taken to travel from that area, which would delay the arrival of surge personnel by at least 3 to 5 hours minimum. In addition, South Australia is unique in that it shares land borders with every other mainland State and Territory with the exception of the Australian Capital Territory. The impact of this is that establishing and maintaining numerous remote border checkpoints is a complex operation requiring significant levels of personnel in remote areas, depending on the nature of border restrictions … … settings can and do change rapidly*'.[91]

112. SAPOL members at the Serviceton checkpoint were reliant upon information provided by travellers and members of the public in order to gauge the extent of the backlog. The layout of the Serviceton checkpoint, off to the side of the Highway in a large parking bay/rest area, meant that it was not possible for border personnel to visually monitor the buildup of traffic from the position in which they were processing travellers.[92] Sergeant Watts was informed by a traveller at approximately 12.10am that the queue stretched approximately six kilometres back into Victoria whilst Brevet Sergeant Bakkelo had also been informed by several heavy vehicle drivers that the queue stretched five kilometres or more. Assistant Commissioner Patterson indicates that '*a line of this length was unusual and had not been experienced in respect of earlier closures of the border nor following any earlier changes to entry restrictions*'.[93]

113. Assistant Commissioner Patterson indicated in his statement that '*I am informed by Senior Sergeant Chris Holland, Traffic Planning Coordinator within EMES (SAPOL's Emergency and Major Events Section) that there is a balancing act in regard to safety in terms of how far out from a stoppage to 'temper', or 'step down', the speed of traffic. This is because, if speed tempering is established too far from the relevant point of stoppage, evidence has shown that traffic moving in an altered speed zone where there is no visible reason to slow down will speed up and ignore the tempering signs. In a situation where lengthy queues are the exception rather than the norm, this is a key consideration. Further, on undivided roads such as at the Service checkpoint it is common practice and a requirement of Australian Standards to replicate the same speed zone on the opposite direction of travel to avoid the situation of high speed traffic travelling on one side of the road whilst traffic travels at low speed on the other. Therefore, the longer a tempering zone on an undivided road the more inconvenience there is for traffic travelling in the other direction*'.[94]

[91] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p329.
[92] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp330.
[93] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, pp330.
[94] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p315.

114. Following Steven's death, '*the TGS for the Serviceton checkpoint was amended, extending the tempered speed zone out to three kilometres into Victoria from the border in order to further improve safety in the event of queueing. This amended TGS was installed at the Serviceton checkpoint on 23 February 2021. The TGS for other border checkpoints with high volumes of traffic were also subsequently amended to extend out their tempered speed zones*'.[95] Subsequent to the collision, SAPOL requested that VicRoads install further VMS five to ten kilometres out from all major static points on the Victorian border when border checkpoints are running with a warning of 'beware of queued traffic*'.* Commissioner Patterson indicates '*I understand that this request was forwarded to each regional area and the signs were provided and installed*'.[96]

115. Subsequent to the collision, Border Commander Superintendent O'Donovan:

    a) Personally met with all Victoria Police Regional Commanders along the eastern border with Victoria to establish and in some cases re-establish relationships and open lines of communication in the event of future border closures; and

    b) Re-initiated recurring meetings with senior members of Victoria Police COVID Command, during which current topics and impending matters are discussed to allow for improved support and responses to any road border closures.

116. Subsequent to the collision, Superintendent O'Donovan has also actioned the development of 'COVID Operations; Border Operations; Surge Trigger Plan' (the 'Trigger Plan') relating to the standup of border checkpoints following changes to Directions which, amongst other things, now includes the specific requirement for the Border Commander to immediately advise relevant interstate policing jurisdictions of any South Australian border restrictions. The Trigger Plan also includes the specific requirement for the Border Commander to advise relevant trucking industry contacts.

117. The Trigger Plan also includes the requirement for the Police Forward Commander to make an assessment of whether a SAPOL vehicle with flashing lights constantly re-positioning itself at the rear of queued traffic (referred to as a 'tail-end charlie') should be employed for traffic queue management where the restrictions are creating delays in the movement of traffic potentially creating risk. In addition, SAPOL's Border Operations Briefing (given by the Forward Commander to staff deployed at border checkpoints) was also amended following the collision to the same effect.

[95] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p334.
[96] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p334.

118. Ultimately the SAPOL Commissioner submits '*the establishment of the various border restrictions including the closure described in this statement was a dynamic situation. The scale of the backlog was unanticipated. The Direction 36 closure was the first time that South Australia had initiated a 'snap' closure of the South Australia/Victoria border; that is a closure with only a small number of hours notice. The press conference provided approximately eight hours notice of the intended closure which appears to have resulted in a large increase in the number of vehicles which had left the Greater Melbourne area arriving at the Serviceton checkpoint a short time prior to midnight. When the South Australia/Victoria border had been 'closed' previously, it had been possible to provide the public with significantly greater advance notice*'.[97]

119. As part of the coronial investigation enquiries were also undertaken to confirm that the Serviceton border checkpoint as it was operating on 11 February 2020 was in accordance with the relevant Australian Standard AS 1742.3:2019. A statement provided by Christopher Thornton, General Manager, Health, Safety, Environment and Quality of Altus Traffic Pty Ltd stated '*to the best of my information, knowledge and belief, no person employed by Altus Traffic (including me) can provide confirmation that the Serviceton border checkpoint was operating in accordance with the Standard on 10-11 February 2021 as no Altus Traffic employee was on site for the reasons previously provided*'.

120. The Inquest Brief contained a copy of the TGS developed by Altus Traffic and endorsed that the TGS complied with the Standard.

121. On 15 February 2021 following the collision, Sergeant Wright and Leading Senior Constable Rose attended the Western Highway, Serviceton between the collision scene and the South Australian border and recorded the warning signage in existence:

Distance from South Australian border	Warning Signage located on southern side of Western Highway facing westbound traffic heading towards South Australian border
1.6 kilometres	Powered digital sign alternating "Road Closed Ahead" "SA BORDER CONTROL"
1.07 kilometres	80km/h speed sign raised on a post
830 metres	80km/h A-frame
530 metres	60km/h A-frame
380 metres	25KPH and ROADWORKS signs
310 metres	25KPH and PREPARE TO STOP signs

[97] Statement of Assistant Commissioner Patterson, South Australia Police, Inquest Brief, p336.

122. It is observed that Sergeant Wright used as his zero point for his observations the intersection of the Western Highway and Serviceton North Road (and not the border checkpoint as the zero point). It is further noted that there are some minor discrepancies in the distances between signages. For example the TGS defines a 250m distance of separation between the 80km/h and 60km/h signage whereas Sergeant Wright recorded a distance of separation of 301m. Likewise the TGS defines a 110m distance of separation between the 60km/h and the 25km/h & Prepare to Stop signage whereas Sergeant Wright recorded a distance of separation of 147m. I am of the opinion that nothing material arises from these minor discrepancies.

123. Combining the evidence contained within the statements of Assistant Commissioner Patterson (SAPOL), Christopher Thornton (Altus) and Sergeant Wright (Victoria Police) I am satisfied that the Serviceton border checkpoint as it was operating on 11 February 2020 was in accordance with the relevant Australian Standard AS 1742.3:2019.

124. SAPOL and Assistant Commissioner Patterson are to be commended for both their level of cooperation with the coronial investigation, as well as their comprehensive incident debrief, review and mitigation process. The coronial investigation has been greatly assisted by SAPOL's preparedness to assist with and engage with the coronial investigation, and the provision of timely, comprehensive and accurate statements.

125. Whilst a number of deficiencies have been identified, primarily in respect of (i) communication in respect of the hard border closure with both relevant Victorian Government Departments and agencies and the trucking industry; and (ii) management of the Serviceton checkpoint including surge staffing capabilities and management of queuing traffic, I am satisfied that SAPOL's own internal debrief, review and mitigation process has appropriately addressed all relevant issues and that this remediation will render it much less likely that such a situation would repeat itself.

126. Further I find that to the relevant standard, none of the shortcomings or deficiencies identified were causative to the fatal collision. Assistant Commissioner Patterson submitted in his statement that ''*as part of policing there is frequently a cause to close sections of road with little or no notice. I am informed that fatalities or serious crashes occur approximately 50 times per year on the Dukes Highway (the SA extension of the Western Highway), often resulting in line-ups of similar lengths if not longer and at times no mitigation measures are able to be put in place. The area where the collision occurred was on a straight section of road and all other vehicles that formed part of the backlog had been able to come safely to a stop, with the lights of the stationary vehicles waiting in the queue serving to warn approaching traffic*'. I accept this submission noting the forensic analysis and findings of the Major Collision Investigation Unit, further discussed below.

UNEXPLAINED DRIVER ERROR

127. At the time of the collision Steven held a current South Australian driver licence with a Multi Combination endorsement (R MC) and worked full time as an interstate truck driver employed by Allan Miller Transport Training.[98]

128. Upon commencing with Allan Miller Transport Training, Steven was paired with Robert Dalton as his 'driver/buddy driver/mentor'.[99] On the first day he accompanied Steven whilst he drove a B trailer from Mawson Lakes to Mile End, reversing at the Mile End site, then driving back to Mawson Lakes and coupling the trailer set back up. In Robert Dalton's opinion '*his driving abilities from that day were inattentive. He displayed no forward planning, followed other vehicles too close, he was a reactive driver rather than a proactive driver … …I thought he was a "good" candidate for the traineeship because he had the truck driver temperament and the work history that would make him a good long-term employee for Allan Millar Transport Training, not necessarily the driving ability*'.[100]

129. Steven was offered a traineeship with Allan Millar Transport Training and spent several days with Robert Dalton after he was employed. In his opinion '*it was becoming apparent that Lawrie didn't have the aptitude to become a truck driver. He wasn't learning very quickly and he was resistant to instruction. Lawrie would follow too closely and be inattentive. I made comments to him on dozens of times that he was following too close or not paying attention. I would describe him as being "ditzy" and lacked concentration. As a passenger in the truck I felt "unsafe" and think he was a risk on the road. I would describe him as a "novice" driver. I was of the opinion that Lawrie thought he was a "super trucker" and "knew everything"*.[101] Robert Dalton also indicates that in October 2020, Steven was given a written employee warning after he uploaded footage of himself driving a truck up the South Eastern Freeway on his personal Facebook page.[102],[103] Robert Dalton also gives evidence that a couple of days prior to the crash '*Lawrie and I had gone to Magill Road to collect a mattress, he nearly rear ended a car that was turning right. I had to tell him there was a car turning and it took about 2 seconds to react*'.[104]

[98] Exhibit 30, Inquest Brief, pp794-795.
[99] Statement of Robert Dalton, Inquest Brief, p231.
[100] Statement of Robert Dalton, Inquest Brief, pp232-233.
[101] Statement of Colin Wardrop, Inquest Brief, p234.
[102] Statement of Colin Wardrop, Inquest Brief, p235.
[103] Statement of Peter Simmons, Inquest Brief, p254.
[104] Statement of Robert Dalton, Inquest Brief, p238.

130. Peter Simmons, the Managing Director and Owner of Allan Miller Transport Training gives contrasting evidence that '*in about August 2020, Lawrie started doing two up driving with me … … I would describe his ability to drive a truck as "capable" meaning he needed some coaching with steering and observation. He needed some help with the work diary and completing that … … Lawrie had a good attitude to truck driving and was very keen. He asked a lot of questions to help himself improve. I would ask him to do something and he would seek clarification. He was grateful for any tips and tricks that I could show him. I thought he would make a career line haul driver. He had the potential to be an excellent driver*'.[105]

131. Colin Wardrop expressed in his statement concerns in respect of Steven's driving, saying '*I haven't driven with Steven all that much, but I recall one trip when he and Leonie were moving in and I drove with him from Auburn. He had a poor attention span and was easily distracted. That was around May 2020*'.[106]

132. Investigations revealed Steven was familiar with the route and driving at the time when the collision occurred. Senior Constable Sarvas, HVEU, South Australia Police following an analysis of 2021 work diary records in respect of Steven opined that '*LAWRIE was familiar with night time driving conditions as part of the change-over run … … He regularly commenced work at Wingfield between 8.00pm and 9.00pm. LAWRIE had done multiple change overs (in excess of 20 trips) to either Nhill or Dimboola during this time frame. This journey and time of night driving was not unfamiliar to him*'.[107]

133. Marcus Vonzieden, a self-employed truck driver driving a Volvo B-Double combination that evening had been stationary in the traffic lineup for about 20 minutes prior to the fatal collision and was approximately 200 metres in front of the collision. Marcus indicated that '*just before the crash a truck was coming the other way. He had either LED or HID lights that blinded me. When you can't see when you're driving you look down for the fog line to make sure you stay on the road. I don't know if this is what the driver who crashed was doing, to explain why he didn't see the truck stopped in front of him because the truck with the lights had just passed me when I heard the bang*'.[108] Ali Raza Naib, the driver of the B-Double combination that Steven directly impacted however gives evidence '*I can't recall observing any traffic approaching from the other direction that may have had its light on prior to the collision*'.[109]

[105] Statement of Peter Simmons, Inquest Brief, p253.
[106] Statement of Colin Wardrop, Inquest Brief, p225.
[107] Affidavit of Senior Constable Rebecca Sarvas, South Australia Police, Inquest Brief, p575.
[108] Statement of Marcus Vonzieden, Inquest Brief, p266.
[109] Statement of Ali Raza Naib, Inquest Brief, p277.

134. Further I note the forensic crime scene analysis undertaken by the Major Collision Investigation Unit. D/A/Sergeant Frith made the following relevant observations:

a) '*for vehicles travelling generally west, the road descended from a crest in the road, approximately 1100 metres east of the collision scene, to a flat section of road leading to the collision scene'*
b) *'The road was dry, the weather was fine, and visibility was good'*
c) *'I was unable to identify any pre impact braking marks from this truck'*
d) '*from the level of damage to all the vehicles, it was evident to me that truck 3 had been travelling at speed when it impacted the stationary truck 2*'.

135. Detective Sergeant Hay, Collision Reconstruction Unit following his analysis opined:

a) *'Based on the lack of pre impact skidding and the fact that the rear end of the Volvo combination was approximately over the area of initial impact, it is my opinion that the Volvo combination was travelling at approximately 98km/hr when it ran into the rear of the Kenworth combination*'.[110]

b) '*It is my opinion that the Volvo driver did not apply the brakes on his combination prior to impacting the rear of the Kenworth combination'.*[111]

136. Finally, I note Detective Sergeant Hay's conclusion, '*... ... when I take into account the UHF radio, the turning on of the rear hazards lights and the large number of vehicles queued, this collision should not have required an emergency response and should have been avoidable by an alert driver ... ... for an unknown reason the driver does not appear to have reacted to the queue of traffic stopped on the Western Highway. I am unable to explain why the driver failed to react to the stopped vehicles*'.[112]

137. I accept Detective Sergeant Hay's opinion. On the basis of all the available evidence, Steven had clear visibility along a flat, straight stretch of the Western Highway as he approached the queued traffic. Further, both the rear hazard indicators as well as the brake lights should have provided sufficient warning in respect of the queued traffic. I accept Detective Sergeant Hay's opinion that, '*this collision should not have required an emergency response and should have been avoidable by an alert driver ... ... for an unknown reason the driver does not appear to have reacted to the queued traffic*'. This coronial investigation has failed to identify a precise reason as to why Steven failed to react to the queued traffic and I find, on the balance of probabilities, that unexplained driver error is the cause of the fatal collision resulting in Steven's passing.

[110] Statement of Detective Sergeant Hay, Inquest Brief, p647.
[111] Statement of Detective Sergeant Hay, Inquest Brief, p650.
[112] Statement of Detective Sergeant Hay, Inquest Brief, p655.

HEAVY VEHICLE NATIONAL LAW (HVNL)

138. Lindy Pascoe, Head of Chain of Responsibility and Compliance, Deliveries with the Australian Postal Group (which includes StarTrack) indicates that:

    a) Steven was accredited to the National Heavy Vehicle Accreditation Scheme for Basic Fatigue Management.[113]
    b) Prior Work Diary Pages indicated compliance with legislative Work/Rest hours as prescribed in the *Heavy Vehicle National Law* 2012 and its associated Regulations. The GPS data also indicates compliance with legislative Work/Rest hours throughout the journey.[114]
    c) A Safe Driving Plan was provided to Steven and it contained sufficient driving and rest times to complete the journey without undue pressure.[115]

139. On the 11 February 2021 Sergeant Williams attended Steven's employer, Transport Training Solutions Pty Ltd trading as Allan Miller Transport Training, and utilising authorities under the Heavy Vehicle National Law (HVNL) seized numerous exhibits including Work Diary pages, Driver Handbook, Guardian footage, non-conformance reports and a range of other material.[116]

140. Senior Constable Sarvas attached to the Traffic Services Branch, Heavy Vehicle Enforcement Unit (HVEU), South Australia Police following a review of this documentation opined, '*with respect to the number of non-conformance reports for LAWRIE, it shows that LAWRIE, as a new driver and employee to Allan Miller Transport Training, was being closely monitored. His work diary records were being closely scrutinised and when breaches occurred they were being identified appropriately as part of the company's compliance efforts*'.[117]

141. Investigations by the HVEU '*revealed there was a deficiency in company practices relating to the management of distraction and fatigue events identified by Guardian*'.[118] Consequentially the HVEU issued an improvement notice to Transport Training Solutions Pty Ltd on Monday 16 August 2021 requiring them to develop and implement a policy and procedure for the management of verified Guardian events.[119]

[113] Statement of Lindy Pascoe, Inquest Brief, p302.
[114] Statement of Lindy Pascoe, Inquest Brief, p303.
[115] Statement of Lindy Pascoe, Inquest Brief, p303.
[116] Affidavit of Senior Constable Rachel Sarvas, South Australia Police, Inquest Brief, p565.
[117] Affidavit of Senior Constable Rachel Sarvas, South Australia Police, Inquest Brief, p570.
[118] Affidavit of Senior Constable Rachel Sarvas, South Australia Police, Inquest Brief, p574.
[119] Improvement Notice SAP2100034265 dated 16 August 2021, Inquest Brief, p580.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Steven James LAWRIE, born 06 April 1974;

    b) the death occurred on 11 February 2021 at Western Highway, Serviceton, Victoria, 3420, from EFFECTS OF FIRE IN THE SETTING OF A MOTOR VEHICLE INCIDENT (DRIVER); and

    c) the death occurred in the circumstances described above.

143. I find, to the requisite standard,[120] that:

    a) There is no evidence of mechanical fault or failure;

    b) There is insufficient evidence to support a finding that Steven was distracted by mobile phone usage, noting the limitations identified in respect of interpreting 'DATA' and whether that represents active user input or background/passive download;

    c) There is insufficient evidence to support a finding that fatigue, including Steven falling asleep at the wheel, was a contributory factor;

    d) There is insufficient evidence to support a finding that Steven suffered a cardiac arrhythmia (or other medical episode);

    e) Steven did not intentionally take his own life;

    f) The hard border closure between Victoria and South Australia and subsequent operation and management of the Serviceton border checkpoint on that border was not a causal factor in the fatal collision; and that

    g) Unexplained driver error was the most likely cause of the fatal collision resulting in Steven's passing.

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

145. I order that this finding be published on the Coroners Court of Victoria website.

[120] That is 'on the balance of probabilities', and subject to the principles enunciated in *Briginshaw v Briginshaw.*

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

a) Margaret Lawrie, Senior Next of Kin

b) Leonie Fitzgerald

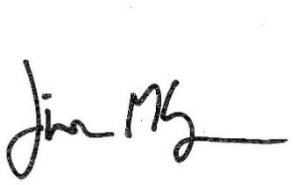
c) Chief Commissioner of Victoria Police, Mr Shane Patton APM

d) Commissioner of South Australia Police, Mr Grant Stevens APM

e) Director, Allan Miller Transport Training

f) Coroner's Investigator, D/A/Sergeant Frith, Major Collision Investigation Unit

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 13 May 2022

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.

APPENDIX A | TIMELINE | SETUP, ESTABLISHMENT & OPERATION

BORDER CHECKPOINT | SERVICETON | SA-VIC BORDER

Date	Time (ACDT)	
4 Feb 21	6.16pm	Direction #34 was made and became operational. Altus was subsequently contacted and directed to reactivate the TGS at the Serviceton checkpoint.
5 Feb 21		Serviceton checkpoint reactivated.
6 Feb 21		Superintendent O'Donovan (COVID Border Commander) visited the Serviceton checkpoint as a part of a larger visit to checkpoints on the Victoria/South Australia border. Superintendent O'Donovan confirmed with Senior Sergeant Holland that the traffic management arrangement for the checkpoint had been individually designed and approved for the site in accordance with relevant Australian Standards.
10 Feb 21	~3.00pm	Inspector Walsh (COVID Border Police Forward Commander) participated in a phone conversation with other COVID-19 Command members. At that meeting no plans were put in place to deploy additional staff to the Serviceton checkpoint or other border sites as a result of the impending change in Direction. This decision was reached because of the frequency of changes to Directions and experience had demonstrated that night shift traveller numbers had been manageable with the rostered staffing levels. Any surges of traffic had previously been able to be cleared with rostered staff allocated to the sites.
	~3.30pm	Inspector Walsh conducted a briefing to all border checkpoint members via a Government Radio Network multi-agency radio talk-group regarding the impending change in Direction. Supplemented by an email to all members deployed at that time, including night shift members.
	3.41pm	SAPOL Commissioner press conference re: Direction #35 to be replaced by a new direction as of midnight that night, resulting in the Victoria/South Australia border being 'closed' as of that time.
	7.00pm	Night shift relieved the day shift at the Serviceton checkpoint. Sergeant Watts was the nightshift supervisor assisted by Brevet Sergeant Bakkelo and Senior Constable Chatfield.

	8.56pm	[52] Inspector Walsh spoke with personnel at the Serviceton checkpoint and was informed at that time the traveller numbers were steady but manageable with current staffing levels. Inspector Walsh instructed Sergeant Watts to wave through heavy vehicles if there were any traffic surges to reduce traffic buildup. Heavy vehicle drivers were considered as "*essential travellers*" under the relevant Directions and the 'wave-through' process was an accepted process to ensure safety and reduce traffic build-ups.
	9.03pm	SAPOL Facebook post and tweet were published confirming the Direction 36 border closure (followed by a media release at 9.05pm).
	~9.30pm	[53] Inspector Walsh spoke with Communications Shift Manager Inspector Jason Phillips requesting an on air broadcast to occur to night shift border personnel about the impending border closure (that occurred at 9.43pm). Purpose to reinforce awareness of the Directions change and that any travellers who arrived at the borders before midnight, but who were held up with processing, could be given some flexibility as to having arrived on time.
	~9.40pm	Inspector Walsh spoke with Sergeant Watts and it was reported that traffic was still manageable at the Serviceton checkpoint and there had been no surges.
	9.47pm	Direction #36 formally made
	10.49pm	Inspector Mazik provided email advice to a broad internal SAPOL distribution list, including Superintendent O'Donovan, Inspector Walsh and those deployed to the Serviceton checkpoint (refer CWP 10) containing the operational interpretation of Direction #36.
	11.25pm	Serviceton checkpoint member Brevet Sergeant Gavin Bakkelo sent a photo of traffic in the work area of the Serviceton checkpoint to Inspector Walsh indicating a buildup of traffic in this area.
	11.31pm	Direction #36 published on SA websites/social media/media release
11 February	12.01am	Direction #36 became operational and border closure took effect.
	12.10am	[56] Sergeant Watts was informed by a traveller he was processing that the queue of waiting vehicles extended for approximately six kilometres.

12.15am	Inspector Walsh was contacted by Sergeant Watts and advised of the large backlog of travellers and perceived issues with the CBTR system.
12.15am	Sergeant Watts advised Police Communications of the backlog at the Serviceton checkpoint.
12.35am	[63] Inspector Walsh contacted the Mount Gambier supervisor Sergeant Andrew Beaufort who identified additional staff to assist at the Serviceton checkpoint.
12.35am	[63] Inspector Walsh contacted Sergeant Watts to inform him of the CBTR system options and additional staffing arrangements.
1.30am	[50] Senior Constable First Class Peter Finlay arrived, was briefed and commenced processing vehicles. Constable Kim Do had arrived a short time earlier and had also commenced processing vehicles.
1.35am	Inspector Walsh contacted Sergeant Watts and was advised that the further personnel had arrived at the Serviceton checkpoint.
~1.50am	Collision occurred.