MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of James William Espie,

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is James William Espie;
b) Mr Espie died as a result of injuries sustained in a motor vehicle crash whilst driving a prime mover and trailer in the course of his employment;
c) The cause of death was chest and head injuries and asphyxia; and
d) Mr Espie died on 25 March 2019 near Piccaninny Point, Chain of Lagoons, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Espie's death. The evidence comprises the Police Report of Death; an opinion of the Forensic Pathologist who conducted the autopsy; toxicological evidence; police, family, witness and employer affidavits; expert crash investigation evidence; vehicle inspection evidence; medical records and reports; and forensic evidence.

James William Espie was born in Dandenong, Victoria on 23 August 1946 and was aged 72 years at his death. He was married, had three children and worked as a truck driver with BridgePro Engineering Pty Ltd (BridgePro) in Latrobe. He lived with his wife, Margaret, at East Devonport.

Mr Espie had a long history of truck driving and working within the trucking industry in various states of Australia, and had an excellent driving record. He and his wife had previously owned a car carrier business. They also assisted their son, Anthony, with his trucking business before Anthony tragically passed away in 2014. Mr and Mrs Espie's two other adult sons are also deceased. On 15 January 2018 Mr Espie commenced employment on a casual basis with BridgePro as a truck driver.

Mr Espie was in good health and under the regular care of his general practitioner. It appears that his last visit to the doctor before his death was on 31 December 2018 for the purpose of a check-up, which showed no health issues. In previous doctor's visits, his cholesterol levels were being monitored and controlled. He did not drink alcohol and lived a healthy lifestyle.

Circumstances Surrounding the Death

On 25 March 2019 Mr Espie awoke at 3.45am, walked the dog and left for his work shift at 4.20am. Mr Espie was driving an Iveco prime mover and Freighter trailer, his load consisting of a concrete bridge span. He commenced driving at about 5.00am from BridgePro's Latrobe depot.

Mr Espie was travelling in convoy with another BridgePro prime mover and trailer with the same load, being driven by Mr Raymond Gray. The trip was expected to take in excess of four hours, with the destination being Weldborough in the north east of the State. Mr Espie knew the route and the road very well. He rang his wife at 7.30am stating he was stopped at Campbell Town for a break.

At around 8.45am, Mr Stephen Hinks, a motorist, drove up behind Mr Espie's vehicle just north of Bicheno on the Tasman Highway. Mr Espie was driving behind Mr Gray in the convoy. Mr Hinks observed that Mr Espie's prime mover and trailer were drifting on the roadway, apparently due to heavy crosswinds, and chose not to overtake at that stage. Upon coming into roadworks and stopping, he observed Mr Espie to briefly alight from his vehicle to undertake an inspection of it before driving off again. After the area of the roadworks, Mr Gray's vehicle pulled further in front of Mr Espie's vehicle and went out of sight.

In his affidavit, Mr Gray described events that followed:

> *"Jim was following but was some distance behind, having dropped off around Doctor's Creek. I approached a bend on the road, with a downhill approach to a left-hand bend. As I was coming down the hill, I was doing about 70 km/h and felt that I was travelling a bit quick for the roadway. I made a comment to Browny, "oh, forgot about that one" and I washed the speed off straight away, using the trailer break a little bit. I would have slowed to about 40 km/h. I then negotiated the left hand bend without issue. The road surface was dry and there was no obstruction on the roadway. I'm not sure how far behind me Jim was at this point, but in the minutes prior to the crash, he was visible in my mirrors. At some points during the trip, Jim was up behind me, then at other times he'd drop away, but then he'd catch up again. There were signs advising of the corner, but these are easily missed if you looked away for even a moment….."*

Mr Gray goes on to state that as he reached the top of the rise, he heard a "bang" and then a "massive crash" which he immediately thought must have been Mr Espie's vehicle. In his affidavit he described immediately stopping and jogging back towards the corner at the bottom of the hill. There, he saw that Mr Espie's vehicle was on its roof, with the trailer twisted on the eastern side (incorrect) of the roadway. The concrete bridge beam had come off the trailer.

He knew that Mr Espie was trapped inside the crushed cabin, which was very difficult to access, and there was no response when he called to him.

Emergency services attended the scene of the crash and, with difficulty, gained access to Mr Espie. Attending ambulance paramedics determined that he was deceased. A thorough and very competent crash investigation was then conducted by Senior Constable Michal Rybka, who was at the scene shortly after the crash.

The location of the crash, as described by Senior Constable Rybka, was on the Tasman Highway, 3.25 kilometres south of the junction with Elephant Pass Road in an area known as Picaninny Point. At that location, the highway comprises a single southbound traffic lane and a single northbound traffic lane, separated by double continuous white lines. Senior Constable Rybka concluded, as a result of his investigation, that when Mr Espie approached the sharp left curve with an advisory speed of 45km/h, he was travelling at about 90km/h. Mr Espie slowed somewhat as he negotiated the curve. Nevertheless, the trailer had already started to lift off the roadway, veering onto the incorrect side of the roadway, rolling over on its right side with the momentum taking the prime mover with it. The cab of the prime mover was crushed, causing fatal injuries to Mr Espie.

Senior Constable Rybka calculated that the speed required to cause a rollover of this vehicle (taking into account its load) on this left curve was 76km/h. Mr Espie entered into the curve at at an excessive speed, being greater than the rollover threshold of 76km/h. This also exceeded the posted advisory speed sign of 45km/h.

The vehicle was inspected after the crash by a safety and compliance officer of the National Heavy Vehicle Regulator. The inspector provided a thorough report for the investigation which indicated that he found no defects in the truck or trailer that would have contributed to the crash. Additionally, he concluded that the load was properly secured and the vehicle was compliant with all required standards. I accept his opinion.

Toxicology testing showed no alcohol or drugs in Mr Espie's body at the time of the crash. He was wearing his seat belt.

An autopsy was carried out by Dr Christopher Lawrence, the then State Forensic Pathologist, who determined that Mr Espie died as a consequence of complications of head and chest injuries and mechanical asphyxia following collapse of the cab in a semi-trailer rollover. I am satisfied, based upon the medical and autopsy evidence, that Mr Espie did not have any medical event that contributed to the loss of control of his vehicle.

Comments and Recommendations

Pursuant to Section 28 of the *Coroners Act* 1995, it is appropriate to make the following comments.

Mr Espie died at his "workplace" (as that term must be construed) of unnatural causes. As such, his death would ordinarily be required to be the subject of a public inquest pursuant to section 24 of the *Coroners Act* 1995. However, I have received a representation from the senior next of kin, Mrs Margaret Espie, under section 26A(2) of the Act, that she does not seek that an inquest be held. Further, I am satisfied that, under section 26A(3) of the Act, it is not contrary to the public interest not to hold an inquest. I have therefore decided not to do so.

It is, however, appropriate to make brief comments upon my investigation into workplace issues that may have been connected to Mr Espie's death. I am satisfied upon the comprehensive evidence that BridgePro, as Mr Espie's employer, did not do any act or omission that contributed to his crash. Mr Espie had had previous employment driving trucks and was an experienced truck driver generally. Mr Aaron Brimfield, managing director of BridgePro, stated in his affidavit that as Mr Espie was employed on a casual basis, he was not required to be subject to mandatory medical testing. He stated, however, that Mr Espie did not have any medical issues at work and he appeared to be a very fit and healthy older gentleman. Mr Brimfield stated that Mr Espie's death had prompted the company to change its policy, requiring all staff to undergo pre-employment medical testing.

I am satisfied that the vehicle driven by Mr Espie was maintained appropriately and in good working order. I am satisfied that the evidence in the investigation reveals no other safety or procedural issues relating to the company bearing upon Mr Espie's death. BridgePro Engineering Pty Ltd has been forthcoming in providing all requested information to assist with this investigation.

I extend my appreciation to investigating officer, Senior Constable Michal Rybka, for his most helpful investigation and report.

I note that WorkSafe Tasmania personnel were notified of the crash by police attending the crash site. In his report, Senior Constable Rybka indicated that WorkSafe personnel declined to attend and have not corresponded with Police Crash Investigation Services since that time. I observe that WorkSafe Tasmania may be well placed to provide investigative assistance in employment-related vehicle deaths such as that of Mr Espie.

I am unable to determine the specific reason why Mr Espie failed to slow to a safe speed before negotiating the curve. Although he was familiar with the road, he may have been briefly distracted for an unknown reason, such distraction having tragic consequences.

I convey my sincere condolences to the family and loved ones of James William Espie.

Dated: 28 October 2020 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner