MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the death of Gary Wayne Walker

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

a) The identity of the deceased is Gary Wayne Walker (Mr Walker);

b) Mr Walker died as a result of traumatic asphyxia due to, or as a consequence of, a motor vehicle accident;

c) Mr Walker's cause of death was traumatic asphyxia; and

d) Mr Walker died on 4 May 2020 on the Arthur Highway between Murdunna and Eaglehawk Neck, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Walker's death. The evidence includes;

a) Tasmania Police Report of Death for the Coroner;
b) Affidavits verifying identification and life extinct;
c) Affidavit of the forensic pathologist, Dr Andrew Reid, who conducted the post mortem examination;
d) Forensic Science Service Tasmania – Toxicological and Analytical report;
e) Ambulance Tasmania electronic patient care record;
f) Statutory declaration of Wayne Rice declared 12 May 2020 and affidavit sworn 12 May 2020;
g) Affidavit of Sonia Wood, Mr Walker's senior next of kin;
h) Affidavit of Mark Noonan;
i) Affidavit of Suzanne Barr;
j) Affidavit of Carlo Cassan;

k) Affidavit of Peter Anderton;
l) Affidavit of Louis Temple;
m) Affidavit of Megan Fogarty;
n) Affidavit of Robert Boost;
o) Affidavit of Shane Salter;
p) Affidavit of Clinton Green;
q) Affidavit of Michael Beven;
r) Affidavit of Brian Morey;
s) Affidavit of Constable Michael Boucher;
t) Affidavits of Senior Constable Timothy Keenan;
u) Affidavit of Constable Christian Oakes;
v) Affidavit of Senior Constable Allison Champion;
w) Affidavits of Senior Constable Adam Hall and his collision analysis report;
x) Mr Walker's medical records obtained from the Sorell Family Practice and from the Royal Hobart Hospital (RHH);
y) Service history of the prime mover being driven by Mr Walker at the time of the motor vehicle accident; and
z) CCTV footage, dashcam footage, photographs, employment records, miscellaneous other records, reports and forensic evidence.

This investigation concerns a fatal truck and trailer rollover that occurred at approximately 5:15 AM on 4 May 2020. The accident occurred on the Arthur Highway between Murdunna and Eaglehawk Neck approximately 14.7 km south of the Denison Canal at Dunalley. Mr Walker's death occurred when he was driving the truck and trailer in the course of his employment with BE and CF Morey Pty Ltd.

As Mr Walker died as a result of an accident or injury that occurred while he was at work the *Coroners Act* 1995 (the Act) provides a coroner must hold an inquest.[1] Notwithstanding that provision the Act also provides a coroner who decides to hold an inquest in circumstances such as this must, amongst other things, give notice of that decision to the senior next of kin in writing and within 14 days after receiving that notice from the coroner, the senior next of kin may, in writing, request the coroner not to hold the inquest. That is what has occurred in this case; namely Ms Wood as requested an inquest not be held.[2]

If the senior next of kin makes that request the coroner may decline to hold an inquest if he or she is satisfied that it would not be contrary to the public interest or the interests of

[1] S24(1)(ea) of the Act.
[2] S26A(1) and (2) of the Act.

justice if the inquest were not held[3]. I have reviewed this matter and as a result of that review I am satisfied that it would not be contrary to the public interest or in the interests of justice if an inquest were not held. The reasons why I have come to this view are Mr Walker's cause of death is clear as are the circumstances in which it occurred. In addition there are no suspicious circumstances and no issues associated with general public safety that require investigation.

Background

Mr Walker was born on the 23 August 1977 and was 42 years of age at the date of his death. He was in a long-term de-facto relationship with Ms Wood, they had one daughter and they lived together at their family home in Sorell for approximately 20 years.

Mr Walker was born in Hobart to Mark and Sally Noonan and he is the third child of 5 siblings. When he was 2 years of age his parents separated. Subsequently, his mother married David Walker and he became Mr Walker's stepfather. Mr Walker took on his stepfather's surname. Mr Walker spent his childhood in southeast Tasmania and attended local schools. He completed his formal education in 1993 and commenced an apprenticeship as a cabinet maker which he completed in 1997. Mr Walker also worked at the Pasminco zinc works in Hobart, now known as Nyrstar, for about 5 or 6 years before he returned to cabinetmaking in about 2005. He worked in that trade for a number of different companies for about 6 years before reuniting with Mr Noonan. From that point Mr Walker commenced working in the mining/trucking industry. Mr Walker commenced working for BE and CF Morey Pty Ltd in May 2017. That company has a freight contract for Inghams Chickens at Sorell and it also carts rubbish for clients from Margate, Huonville and Lutana to the Copping landfill facility. When he first commenced this work Mr Walker delivered frozen goods for Inghams to supermarkets. He left that employment in April 2018 and travelled to work in the mines in Western Australia before recommencing with BE and CF Morey Pty Ltd in February 2019. From that time he drove both the refrigeration truck, prime movers and he assisted with maintenance on the vehicles. He left that employment again in July 2019 and travelled Port Hedland to work with his father where he was carting ore from the mines to the port. He again recommenced employment with BE and CF Morey Pty Ltd on 14 October 2019 and worked in that employment until the date of the motor vehicle accident. During this period Mr Walker was the relief driver who drove several of his employer's vehicles and in addition he would assist with maintenance and deliveries.

[3] S26A(3) of the Act.

According to Mr Morey, Mr Walker had undergone a detailed induction when he commenced employment with his company in 2017. The induction process was both paper based and practical. The practical component of his induction consisted of him travelling as a passenger for about 3 weeks to learn what his duties were and where he was to drive to and from. Employees undergo a refresher in the paper based component of the induction every January. This consists of going through the paperwork side of the job along with the work health and safety aspects of the position.

Ms Wood estimates Mr Walker worked an average of 50 to 60 hours per week. He was working Monday to Friday and most Saturdays although he would take the occasional Saturday off. Mr Morey has calculated that since October 2019, Mr Walker worked an average of 57 hours per week. Mr Walker never had a specific start time as his employer's trucks worked both day and night and it would depend on which role he was performing at any given time as to when he would start work.

Mr Walker's Health.

I have obtained and considered Mr Walker's medical records maintained by his general practitioner Dr Birrell. The records reveal Dr Birrell treated Mr Walker for long standing gastro-oesophageal reflux disease and hypertension. In addition he had suffered a dislocated shoulder in September 2007 and he underwent a surgical repair in February 2008. In July 2019, Mr Walker was diagnosed with a hiatus hernia and on 20 March 2020 he was diagnosed with a right inguinal hernia. Dr Birrell says in relation to the hiatus hernia Mr Walker was *"just about to undergo surgery"*. In relation to the inguinal hernia she says that caused him pain when he was sitting in a truck driving and when he lifted things. He was awaiting review for this condition at the RHH.

Mr Walker's movements in the days preceding his death.

Ms Wood says Mr Walker did not work on the weekend preceding the crash[4]. They did not travel far that weekend due to the Covid 19 restrictions. They visited Mr Walker's stepfather on the Sunday[5] morning at Orielton and stayed there until about lunchtime. She says Mr Walker knew he was working the early "chook run"[6] on the Monday which required him to start early and travel to Nubeena to pick up chickens and deliver them to Inghams at

[4] Mr Morey says Mr Walker finished work on Friday 1 May 2020 at approximately 3:30 PM.
[5] 3 May 2020.
[6] Mr Morey says Mr Walker was due to commence work at 2 AM on 4 May 2020 at his yard at Sorell. He was to travel to Nubeena where his truck was to be loaded with chickens at a farm which he was to deliver to Inghams at Sorell. Mr Morey says Mr Walker did this run regularly both day and night but mostly at night. He estimated he would have done this job on approximately 80 previous occasions.

Sorell. On the Sunday she says Mr Walker slept in until around 8 AM. In the afternoon his father visited as did a friend and they had "a couple of beers." Mr Noonan left in the middle of the afternoon but before doing so, Mr Walker invited him for a ride in the truck the following morning which Mr Noonan accepted. Mr Walker received instructions from Mr Morey about his work the next day at approximately 3:50 PM.

Later in the day Mr Walker slept for a few hours. He woke at 6:37 PM and spoke to Mr Noonan and confirmed the arrangements for the next day. Mr Walker then had his evening meal and went to bed. He woke at about 12:50 AM on 4 May 2020. Ms Wood recalls waking up when Mr Noonan arrived but is unaware of the time he arrived. Shortly after, Mr Walker and Mr Noonan left.

Mr Noonan recalls that he and Mr Walker left Mr Walker's residence at approximately 2 AM. They travelled to the depot of Mr Walker's employer on the Arthur Highway and picked up the prime mover and trailer.

Circumstances Leading to the Accident

Mr Walker and Mr Noonan travelled to 505 Nubeena Back Road to collect chickens from KM Holdings Broiler Chicken Farm. This is a business operated by Michael Beven. Mr Beven greeted Mr Walker when Mr Walker was rolling back the side curtains of the trailer. He got back in to the cab of the truck while Mr Beven's employees unloaded the empty crates from the truck and loaded them with chickens and reloaded them back on to the truck. Mr Beven says 6264 chickens were loaded onto the truck with each chicken weighing between 2 and 2.2 kg. He said the load was just under 14,000 kg. Loading commenced at approximately 3:40 AM and concluded on approximately 4:50 AM. Mr Walker left the premises at or about 5 AM in order to drive to Inghams Chickens at Sorell.

Mr Noonan confirms he was a passenger in the truck driven by Mr Walker on this morning. He has provided the following description of the accident:

> *"From memory we passed a couple of vehicles not long after passing the Eaglehawk Neck Hill. Gary would have been travelling at between 70 – 80 km/h as we approached a right-hand bend in the road approximately 5 km north of the top of the neck hill.*
>
> *As we approached the right-hand curve of the road, I believe Gary may have been slightly cutting the corner and perhaps a touch over the white line into the oncoming lane. As Gary began to negotiate the right-hand curve, we noticed bright lights coming in the opposite direction off the straight and into the curve and at that stage Gary dipped the trucks high*

beam lights and started to move across to the left. As the vehicle continued towards us the lights were extremely bright. They were not standard factory lights and they were bright like an added LED light bar or driving lights.

As this vehicle continued towards us it appeared to be either very close to the centre line or even slightly pushing into our lane which required Gary to steer further to the left. As we continued to the left, we passed a vehicle and I could then feel the trailer enter the gravel verge and begin to tip. At that stage I said to Gary "we are going over". Gary tried hard to maintain control but as soon as the trailer went over the truck went with it."

Investigation

(i) At the Scene

Passers-by Mr Temple and Mr Cassan stopped at the scene. Mr Cassan located Mr Noonan in the cab of the truck and assisted him to climb out. Mr Noonan told Mr Cassan, Mr Walker had been driving the truck and he was missing. Mr Salter and Mr Boost are volunteer firefighters attached to the Eaglehawk Neck brigade. Mr Boost is also a firefighter with Tasmania Fire Service. After receiving a message they both attended the scene of the accident and they arrived after Mr Cassan and Mr Temple. They all searched for Mr Walker. It was noted the driver's seat belt was not clipped in and the windscreen was missing. Mr Walker was located trapped under the cab guard of the trailer. Mr Boost informed AT personnel, who had arrived, Mr Walker had been located and he was responsive to voice. A short time later, AT personnel informed those on the scene Mr Walker was deceased.

The records of AT indicate the call to attend the scene was received at 5:34 AM and ambulance personnel were at the scene by 6 AM. Mr Walker was pronounced deceased at 6:20 AM.

(ii) Police Attendance

Constable Boucher received a call to attend the accident at 5:30 AM. He reached the scene at approximately 5:52 AM. It was dark with the only light available being headlights from vehicles and torches. The road was dry and the weather was fine. He requested the attendance of crash investigation services and forensic services. He also closed the roadway. Constable Keenan received a call to attend at 5:36 AM and he arrived at the accident scene at approximately 6:03 AM. He blocked the southern end of the crash scene with his vehicle and spoke to Ms Barr who told him she was the first person on the scene. He spoke to a number of people at the scene and later that day he spoke to Clinton Green who was

assisting the crane operators removing the truck from the scene. Mr Green informed Constable Keenan he was best friends with Mr Walker and he formally identified him.

Senior Constable Hall was advised of the collision at 6:02 AM and he arrived at the scene at 6:35 AM. When he arrived the highway had been closed to all traffic in both directions. He identified, measured and marked all the relevant evidence in this matter and later prepared a detailed collision analysis report and scene survey. He also subsequently conducted visibility testing at the crash scene both during the day and in the dark.

Senior Constable Champion arrived at the scene at 7:40 AM and was briefed by Senior Constable Hall. She examined the scene and took a series of photographs. Her examination of the scene concluded at 6 PM that day.

(iii) Post Mortem Examination

Dr Reid conducted an autopsy on 5 May 2020. After conducting the autopsy and considering post-mortem CT scans and histological and toxicological results, Dr Reid concluded Mr Walker's cause of death was traumatic asphyxia which occurred in the motor vehicle accident. He also says coronary atherosclerosis was another significant condition which contributed to the cause of death. There was no alcohol or illicit drugs detected in Mr Walker's blood sample.

Dr Reid says the evidence indicated to him Mr Walker had been ejected from the cab of the vehicle and then he became trapped and compressed under the overturned rear of the truck/tray. He was trapped across the upper left side of his torso and chest and was found face down. Dr Reid says the nature, degree and pattern of the blunt force trauma injuries to the torso are consistent with this. He also says there are characteristic features of traumatic asphyxia and there is a well-defined demarcation between the upper chest, neck and face where there is congestion and hypostatic petechial haemorrhages and below this arbitrary line where the skin is pale. He says this indicates the area of maximum force or compression under which Mr Walker was pinned and this fatally interferes with the mechanics of respiration. Dr Reid says the thoracic/rib cage cannot move, the lungs cannot inflate properly, and the diaphragm cannot contract effectively, all of which cause congestion of vessels in the peri-diaphragmatic lower chest and upper abdominal region.

Dr Reid says the time between the incident which causes the asphyxia and death is not usually prolonged. In most cases death occurs within the range of seconds to several minutes. In some cases it is associated with purposeless, gross agonal/terminal movements of the limbs. He believes in this case death occurred within the range of 1 to 4 minutes after

the onset of traumatic asphyxia. Any movement subsequently seen say 35 to 40 minutes after the accident is unlikely to have been an agonal movement associated with terminal asphyxia.

In addition, Dr Reid says there was no evidence that an intracerebral or cardiac event caused Mr Walker to lose control of the motor vehicle. This finding is corroborated by the evidence of Mr Noonan.

(iv) Collision Analysis

On this morning, Mr Walker was driving a 2004 Volvo FH prime mover registration FC 3668 together with a 2005 Freighter Maxi – Trans-trailer registration QT 9868. As a result of his examination of the scene and consideration of all of the evidence Senior Constable Hall concludes the vehicle driven by Mr Walker negotiated a right-hand curve in the road and the trailer began to track outside of the line of the truck. This then caused the trailer to overturn onto its passenger side which subsequently overturned the prime mover. The right-hand curve the truck was negotiating at the time of the accident was analysed and a curve radius of 203.22 m was calculated. Engineers from Maxi-Trans who built the trailer calculated the trailer with its payload would have had a centre of mass height of approximately 2.04 m. After analysing the right-hand curve and utilising the centre of mass height Senior Constable Hall calculated the prime mover and trailer should have been able to negotiate the curve at a speed of up to 130 km/h[7] without exceeding its role threshold and tipping over.

He says the evidence at the scene indicates the prime mover and trailer was cutting the right-hand curve and encroaching into the southbound lane prior to the loss of control. Mr Walker was therefore required to take evasive action to correct its road position and avoid a southbound vehicle. Senior Constable Hall says there is no evidence to suggest the southbound vehicle was directly involved in the collision, or even aware the truck was undertaking such a manoeuvre.[8] He says the evidence indicates the loss of control and subsequent tip over was a result of what is known as outboard off tracking, following a sudden swerving manoeuvre to the left to get the combination wholly back into the northbound lane. As a result of that steering manoeuvre the rear of the trailer has tracked outside the truck and it has exceeded the lateral acceleration factor and subsequently tipped over. Senior Constable Hall is satisfied excessive speed was not a factor in the cause of the collision.

[7] Although he notes negotiating this curve at this speed would not be safe.
[8] See the affidavit of Megan Fogarty.

Senior Constable Hall is also satisfied that as result of his examination of the scene of Mr Walker was not wearing his seatbelt. As a consequence Mr Walker was ejected through the front windscreen and he was then trapped under the vehicle.

As a result of CCTV footage, dash cam footage and statements taken by the police Senior Constable Hall is satisfied Megan Fogarty was driving south on the Arthur Highway at the accident scene at the time of the accident. It is her vehicle which Mr Noonan identifies as approaching the curve in the roadway from the opposite direction to that being travelled by him and Mr Walker. Contrary to what Mr Noonan says, Senior Constable Hall indicates Ms Fogarty's vehicle, a 1999 red Holden Jackaroo, was not fitted with any aftermarket or LED style driving lights and there was no evidence to suggest it had been fitted with any such lighting in the few weeks prior to the collision.

Senior Constable Hall conducted visibility testing at the accident scene both during the day and in the dark. During the day southbound vehicles were observed to cut in on the corner away from the centre line and towards the fog line. He notes the camber of the road falls towards the inside of the corner and this also assists as the vehicle *"will naturally manoeuvre towards the negative camber of the road."* On a night the illumination of headlights of a southbound vehicle illuminates the road between 1.5[9] and 2.5[10] seconds prior to seeing the vehicle itself coming around the corner. Senior Constable Hall says it is not until the vehicle is exiting the corner you can ascertain its road position. From the testing he undertook he is satisfied the swerving manoeuvre of Mr Walker, which ultimately caused the accident, was made due to him reacting to the site of the oncoming vehicle's headlights. In doing so he was trying to correct his road position to avoid a collision. He does not believe Ms Fogarty's vehicle was over the centre line.

I accept Senior Constable Hall's opinion that it was Ms Fogarty's vehicle which was driving south on the Arthur Highway at the accident scene at the time of the accident and I also accept his opinions as to the cause of the accident which he is well qualified to give.

(v) The Prime Mover and Trailer

Mr Rice is a qualified automotive mechanic with over 30 years experience in the automotive industry. He is also an authorised officer employed as a safety and compliance officer with the National Heavy Vehicle Regulator. He examined the Volvo prime mover and trailer involved in this accident on the 6th and 7th of May 2020. He also visited the accident scene at

[9] On low beam.
[10] On high beam.

approximately 10 AM on 4 May 2020. He determined the prime mover was in a roadworthy condition and there was no evidence that a mechanical fault with the prime mover caused or contributed to the accident. His examination of the trailer revealed non-compliant tread depth on 2 tyres fitted to the right-hand side middle and rear axles, an insecure shock absorber was fitted to the left-hand side, another shock absorber fitted to the left-hand side had excessive wear and the left-hand indicators did not operate. He says these defects were not causative of the accident and therefore there was no evidence a mechanical fault with the trailer caused or contributed to the accident.

(vi) Why was Mr Walker not wearing a Seatbelt?

Mr Green is very good friends with Mr Walker and has known him since they started school together in kindergarten. He is also a truck driver who has been driving trucks for around 25 years. He says, like himself, Mr Walker wore his seatbelt religiously. He believes he knows why Mr Walker was not wearing a seatbelt at the time of this accident.

In February 2018 and January 2019 Mr Green had surgery on a right inguinal hernia which was located in his groin area. He is aware Mr Walker had been diagnosed with the same condition in March 2020 and was on a waiting list for surgery. He had a number of discussions with Mr Walker about his condition.

Mr Green says the pain and discomfort he had with his hernia was constant. Coughing, sneezing and twisting the wrong way increased his pain. Before he had his first operation he got to the stage where he was wearing tracksuit pants to work as sitting down all day wearing jeans and a belt made him extremely uncomfortable. At one stage the pain was so extreme he had to click the seatbelt into the buckle first, sit in the seat and then pull the sash part of the belt over his shoulder. That way he was still partly in the belt but he was unable to endure the pain caused by the lap belt over his hips. He had to do this whether he drove a car or a truck. He also noted he was not as large a man as Mr Walker and therefore he infers Mr Walker may have been in more pain than he was.

Mr Green says he spoke to Mr Walker a few weeks before the crash about the pain Mr Walker was suffering. He indicated to Mr Green that due to the suspension seat and the amount of bouncing one endured in the seat Mr Walker was having trouble wearing a seatbelt. Mr Green therefore concludes it was likely this was the reason Mr Walker was not wearing his seatbelt on the morning of this accident.

Ms Wood has also suggests Mr Walker was not wearing his seatbelt because of either the right inguinal hernia or his shoulder injury. Dr Birrell notes that sitting in a truck with his inguinal hernia caused Mr Walker pain and discomfort.

I consider it is likely Mr Walker was not wearing a seatbelt because of the pain and discomfort caused by the right inguinal hernia when he was driving the truck.

Most of the damage to the prime mover was sustained to its left-hand or passenger side which is the side of the cabin in which Mr Noonan was seated. Had Mr Walker been wearing his seatbelt it is more likely than not that he would not have been propelled through the windscreen and then trapped under the vehicle. In those circumstances it follows he would not have passed away from traumatic asphyxia.

Comments and Recommendations

I extend my appreciation to investigating officer Senior Constable Adam Hall for his investigation and report.

The circumstances of Mr Walker's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the Coroners Act 1995.

I convey my sincere condolences to the family and loved ones of Mr Walker.

Dated: 8 September 2022 at Hobart in the State of Tasmania.

Robert Webster

Coroner