



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

(These findings have been de-identified in relation to the name of the deceased, family, friends, youths and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Robert Webster, Coroner, having investigated the death of AB

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

- a) The identity of the deceased is AB ("AB");
- b) AB died as a result of injuries sustained in a motor vehicle crash;
- c) AB's cause of death was blunt trauma of the chest and;
- d) AB died on 13 February, 2023 on private property situated at Boyer Road near Bridgewater, Tasmania.

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

- The Police Report of Death;
- Tasmanian Health Service (THS) Death Report to Coroner;
- Affidavit establishing identity;
- Affidavit of Dr Donald Ritchey forensic pathologist;
- Affidavit of Mr Neil McLachlan-Troup, forensic scientist of Forensic Science Service Tasmania;
- Medical records obtained from AB's general practitioner;
- Records obtained from Ambulance Tasmania (AT);
- Medical records obtained from the Royal Hobart Hospital (RHH);
- Affidavit of KW;
- Affidavit of SE;
- Affidavit of EL;

- Affidavit of QK;
- Affidavit of HD;
- Affidavit of Senior Constable Jamie Hart;
- Affidavit of Constable Shaun Hume;
- Affidavit of Constable Shannon Foden;
- Affidavit of Senior Constable Jimi Morris and his collision analysis report;
- Affidavit of Senior Constable Kelly Cordwell;
- Affidavit of Constable Carly Medhurst;
- Affidavit of Senior Sergeant Adam Archer;
- Affidavit of Mr Craig Shepherd;
- Weather observations for the date of the accident obtained from the Bureau of Meteorology; and
- Forensic evidence, photographs, police body worn camera footage and all-terrain vehicle (ATV) owner's manual.

This investigation concerns a fatal single vehicle crash that occurred at approximately 2:20pm on Monday, 13 February 2023 on a private bush block located on Boyer Road near Bridgewater in Tasmania. At that time AB was the driver of an unregistered Polaris Ranger 904 cc 4x4 all-terrain vehicle (ATV). EL was a passenger in that vehicle. The crash occurred after AB lost control of the ATV as it was being driven downhill on a cleared uneven grass section of the bush block. As a result of the loss of control both AB and EL were ejected from the ATV with AB sustaining fatal injuries. The weather at the time of the crash was fine and the surface of the bush block was dry.

Preliminary Matters

In Tasmania, a coroner's functions are set out in section 28(1) of the *Coroners Act 1995* (the Act). By this section, a coroner is required to find the identity of the deceased, how death occurred, the cause of death and when and where death occurred. By section 28(2), a coroner may make comment on any matter connected with the death; and by section 28(3), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter the coroner considers appropriate.

Coroners complete their written findings pursuant to section 28(1) of the Act in respect of a reportable death after receiving documentary evidence in the investigation. In a small proportion of reportable deaths, the coroner will hold a public inquest, which almost always involves the calling of oral testimony to further assist the coroner in investigating the death and in making findings. Many of the public inquests held by coroners in Tasmania are made

mandatory by the Act.¹ The remaining inquests are held because the coroner considers that a public inquest is desirable in the particular circumstances of the investigation².

When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial; whereas in criminal or civil proceedings the proceedings are adversarial; that is one party against another. In these proceedings I am required to thoroughly investigate the death and answer the questions (if possible) that s28 of the Act asks. Those questions in s28(1) include who the deceased was, how she died (that is the circumstances surrounding AB's death), what was the cause of her death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions.

A coroner does not have the power to charge anyone with a crime or an offence. Nor is it my role to review what the Director of Public Prosecutions did or did not do or how any charges which may be laid with respect to a death are dealt with by a Court. A coroner also does not have power to determine issues associated with an inheritance or other matters arising from the administration of deceased estates. In this case AB's parents have made serious allegations against HD which are unrelated to this crash and her death. Although it is not the role of the crash investigator, Senior Constable Morris, to investigate those allegations he advised KW he would refer them to the appropriate departments within Tasmania Police and he also advised KW to speak directly with CIB. Senior Constable Morris has reported the allegations were investigated and Kingston CIB, who spoke to KW, found no evidence to substantiate the allegations. As part of his investigation Senior Constable Morris seized HD's mobile telephone which was downloaded and there was no evidence found on that phone to substantiate the allegations. The allegations do not fall within the questions set out in s28(1) which I must, if possible, answer or the issues raised in s28(2) which I may comment on or recommendations which, if appropriate, I must make pursuant to s28(3). For these reasons I am not permitted, as a matter of law, to investigate those allegations. Accordingly I do not intend to do so.

As noted, one matter the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by s28(1)(b) upon the coroner.

¹ S24(1) of the Act.

² S24(2) of the Act.

A coroner may comment on any matter connected with the death into which he or she is enquiring. The power to make comment “arises as a consequence of the [coroner’s] obligation to make findings ... It is not free ranging. It must be comment “on any matter connected with the death” ... It arises as a consequence of the exercise of the coroner’s prime function, that is, to make “findings”.³

The standard of proof applicable to a coronial investigation is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.⁴

Background

AB was born on 29 August 2008 in Penrith NSW. She was therefore 14 years of age at the date of her death. She was the third of four children and she resided with her family.

The family moved to Tasmania in 2016 at which time AB attended Glenorchy Primary School for year 4. She completed years 5 and 6 at Mount Stuart Primary School before attending Tarooma High School where she enjoyed English and Mathematics. AB was a very good student. She enjoyed competing in track and field events which included the 400m and 800m, the javelin and shotput. She loved music and watching programs on Netflix and she had a large circle of friends. She loved animals with her goal being to own lots of land and care for lots of animals and practice as a veterinarian.

AB was, at the time of her death, in very good health and was not prescribed any medication. This is confirmed by the medical records.

The Circumstances Leading to Death

Monday, 13 February 2023 was the Regatta Day public holiday in Hobart and its surrounds. That morning EL visited AB at her home after being dropped off by her mother. Also present were AB’s parents. At 10:57am that day AB attempted to contact HD by mobile but was unable to do so. HD lived next door and was the landlord of AB’s family. Being unable to contact HD she instead visited him shortly thereafter. After AB’s parents left home AB and EL left with HD in order to attend his property at Boyer Road.

³ See *Harmsworth v The State Coroner* [1989] VR 989 at 996.

⁴ (1938) 60 CLR 336 per Latham CJ at 347 and Dixon J at 362 and 368-9.

HD's property is approximately 50.5 hectares in size. It has no houses on it. He uses the property to store equipment and run some sheep, goats and chickens. It is normally accessed from Boyer Road through a locked gate. There are two areas on his land which are cleared and resemble an open paddock. The rest of the land is bush. One of the cleared areas is approximately 400m up the access road from Boyer Road whereas the second cleared area is about 600m into the property. The cleared areas are roughly 0.5 to 1 hectare in size. At the very top of the property, just beyond HD's border, there is another large flat area.

Prior to the crash HD had owned the ATV for four to five years. He used it approximately once per week to collect firewood and to assist him in completing other tasks on his land. He described it as a 3 cylinder vehicle which could reach a maximum speed of 30 km/h. When he purchased it the vehicle was rusting and needed new cables which he replaced. More recently the vehicle had a flat tyre on the front right passenger side; it being a left-hand drive vehicle. The tyre would deflate after a few days and would need some tyre sealant and air pumped into it. On the Friday or Saturday prior to the crash AB attended HD's property, used the tyre sealant and re-inflated tyre. The tyre was checked by HD on 13 February 2023 and it was properly inflated. He says the vehicle's lights had been removed as it was never driven at night. In addition the side doors were removed to make access in and out of the vehicle easier. The driver side and middle seat belt were present and could be used however the right passenger side seat belt was cut when his property was broken into about four years ago.

HD says AB visited his property regularly over a number of years because of her love of animals and an interest in outdoor pursuits. She rode as a passenger in the ATV on 10 to 12 occasions over about a two year period. She first drove the vehicle in early 2021 and was taught by HD how to drive it. This consisted of AB sitting next to HD when he drove the vehicle and then he would sit next to her and instruct her while she drove the vehicle. He says in the two months prior to the crash she wanted to drive it more. He would initially drive the ATV up to one of the open paddocks where she would take control of the driving. He had instructed her on where to drive as there was a lot of uneven terrain throughout the property. HD and AB attended his property on 12 February 2023 for approximately one hour. During this time HD conducted some repairs to the front gate and fed his chickens while AB drove the ATV from the second or top paddock down to the first paddock. He observed her driving which he described as "*being quite careful*". On this occasion HD says she drove the ATV for approximately 45 minutes.

On their arrival at the property on 13 February 2023 HD opened the gate on Boyer Road and drove the girls up to the ATV which was parked at the second paddock. They checked

the tyre which was still inflated. HD understood that AB and EL would drive around in the ATV. HD left and drove to the first paddock where he fed his chickens at which time he could hear the ATV being driven. After moving some machinery HD went down to the front gate to conduct some repairs.

Before leaving AB and EL, EL remembers HD telling AB to be careful. EL then says AB drove the ATV around the clearing; which I infer is the second paddock for a while and then onto some trails to a watering hole where they had a swim. EL then drove the ATV for approximately five minutes before AB resumed driving. They returned to the second paddock at which time EL says AB wanted to do some doughnuts around the trees and a metal frame which was situated in the paddock. EL then says: *“[a]s we were going downhill, I think [AB] wanted to do a doughnut around the metal frame. I can then remember looking at her when we approached it and she was frantically trying to steer the buggy as if she had lost control of it. I can’t remember if the buggy got airborne or not but I do remember the buggy turning to the left and it spun really fast, even rolling.”*

EL says AB was ejected from the vehicle through the gap where the driver’s door would have been on the left-hand side and she was still in the vehicle as it spun and rolled. She was holding on to the vehicle as tightly as she could but she was also flung through the gap where the passenger’s door would have been on the right-hand side of the vehicle. The buggy landed on its wheels and EL recalls picking herself up and running to check on AB. The engine was still running so she turned it off with the key. Neither girl was wearing a seatbelt. EL found her phone which had been ejected from the vehicle and rang her mother and then emergency services.

Investigation

Constables Lawrence and Rees responded to a request at approximately 2:49pm from Radio Dispatch Services (RDS) of Tasmania Police that police attend HD’s property because of this crash. Acting Sergeant Hart and Constable Hume were attending another job in Gagebrook when further information provided to them resulted in them abandoning the job at Gagebrook and driving under police lights and sirens to the scene of the accident. They arrived at 3:05pm. Constables Foden and Whitaker were also directed to attend by RDS at 3:56pm.

The records of AT indicate a call was received at 2:21pm and an ambulance was dispatched three minutes later. It arrived at the scene at 2:50pm and was attending to AB by 3:01pm. A helicopter containing a doctor, paramedic pilot and crew was dispatched at 3:07pm and was with AB by 3:25pm. A further vehicle containing 2 doctors was dispatched at 3:06pm and they were with AB at 3:35pm. Despite the provision of extensive treatment AB could not be revived.

Senior Constable Morris was on duty with Senior Constable Cordwell who were attached to crash investigation services. They were contacted by RDS at 3:03pm however they were on Bruny Island at that time performing other duties and so they did not arrive at HD's property until approximately 5:06pm. Neither AB or EL were present when they arrived. Constable Medhurst from Forensic Services arrived at approximately 3:40pm.

At the second paddock a small metal frame was observed in the middle and there were trees to both sides. There was a fence line to the west with one roll of fencing material rolled out to almost its entire length and there was a series of smaller seedlings/sapling trees dotted around the western side along with a dog kennel. On the eastern side of the paddock was a pile of dry firewood. To the north was a cabin and a caravan together with various items such as glass panels and machinery.

Senior Constable Morris measured the downhill gradient with a digital spirit level at various points along the last known path of travel for the ATV; it was heading south. The downhill gradient ranged between 5° and 15° in places. There were no obvious tyre skid marks at the area of impact but there was a fresh divot in the ground around a black cap which was partially buried. This was identified as being the end cap from the tubing which forms the left-hand side of the ATV's bumper/brush guard assembly in which there was grass embedded. The end cap was approximately 2.5m from the driver's front corner of the ATV.

Next there was a small debris field to the right of the black end cap. This debris consisted of parts which were stored in the rear tray of the ATV which were not attached or fitted to it prior to the crash. There was also a tube of tyre seal located in the rear tray. Police witnesses advised this debris was moved from its initial resting place by attending AT officers in order to administer treatment to AB.

A second divot in the ground near to the rear left tyre of the ATV was observed by the crash investigators. The left rear tyre had grass between the wheel rim and the rubber tyre itself indicating an impact with the surface. The impression in the ground in the embedded grass in the rim indicates the wheel rim has dug into the ground as the vehicle rotated almost entirely to its left side prior to coming to rest. AB was found approximately 2.9 m away from the driver's door area of the ATV.

According to an inspection report the ATV had been used for 518 hours which equates to just over 64 x 8 hour days. Research determined its top speed was 35 mph or 56.3 km per hour. After inspecting the ATV Senior Constable Morris was of the view it was in very poor condition. He found it to be in high range with the handbrake disengaged. The ignition key was

located in the ignition switch which was in the off position. There were signs of surface rust on the exposed metal surface all over the undercarriage of the vehicle which included the chassis, running gear and the engine. Plastic coating on some metal parts of the ATV had begun to crack and separate. Tyres showed a good tread depth and they appeared to be holding pressure. There were no obvious signs of damage on the vehicle itself which suggested it had been involved in a crash other than a piece of turf which was wedged in the right-hand side of the bumper/brush guard assembly and some grass located between the tyre and rim at the left rear driver's side. Both driver and passenger doors had previously been removed and the windscreen and seal were located on the grass near to the ATV. The glass had been destroyed with two radial fractures in it. With the windscreen removed the rusty window frame was exposed. The dashboard fittings were loose and had components missing. The front panel which incorporates the headlight housing and radiator grill was missing and the tailgate was not attached.

At the conclusion of his duties at the scene Senior Constable Morris drove the ATV to the front gate due to the tow truck being unable to retrieve the ATV from the scene as a result of the very rough and uneven terrain which could only be traversed by a four-wheel-drive. The ATV started and Senior Constable Morris found the wheels to be tracking correctly and the steering to be fairly consistent with where he was aiming to drive. In so far as the accelerator was concerned he had to press the pedal for quite a distance before the engine responded but when he did acceleration was instant. He felt without the doors in place and without being restrained by a seatbelt there was almost nothing to hold you in the cabin when traversing rough terrain.

The ATV was taken to the police garage in Hobart where on 14 February 2023 it was inspected by Craig Shepherd who is a transport safety and investigation officer employed by the Department of State Growth. He is a qualified automotive mechanic with in excess of 18 years' experience in the automotive industry. He noted the ATV had an automatic transmission and it was manufactured in 2014. As a result of his inspection he found the ATV to be in poor mechanical condition and although still capable of being driven it displayed excessive wear to several key areas including the suspension, steering, seatbelt, tyres, transmission and exhaust. In his affidavit he sets out the damage which he observed. I accept his opinion.

This model of ATV is fitted with three lap/sash seat belts which include one for the driver and two for passengers. There are no seatbelt safety pre-tensioners fitted to this vehicle. The driver's seat belt was found to be retracted in its mechanism able to freely move with the buckle showing obvious signs of corrosion. There were no obvious stretches in the webbing and even with corrosion on the buckle it was able to be secured into its stalk. The far right passenger side seat belt webbing and retractor mechanism was missing altogether however

the buckle was inserted into the stalk. The components of the middle passage seatbelt were all present and appeared to operate correctly.

The owner's manual, at page 28, provides a warning which says "*[f]alling from a moving vehicle could result in serious injury or death. Always fasten your seatbelt securely before operating or riding in the RANGER.*" Instructions are provided to ensure the seatbelt is worn properly. The ATV is also fitted with a hip bar although reference is only made to that device in a diagram on pages 21 and 28. That bar appears to offer support to the driver and passenger against a lateral movement in the seats. It is not an alternative to wearing a seatbelt and would offer little if any protection in the event of a crash.

The ATV is fitted with a number of manufacturer's installed warning labels. Placed on two separate locations on the ATV's dashboard, there are two large warning stickers with the word WARNING highlighted within a highly visible yellow backdrop. Both warning stickers were correctly affixed in their proper positions as referenced in the owner's manual. One of these stickers is displayed on the left-hand side of the dashboard and it provides amongst other things careless or reckless driving is not permitted, operators are to be 16 years of age or older with a valid driver's licence, and people are not to drive or ride in the ATV after using alcohol or drugs. The second sticker is located in the middle of the centre console in clear view of the driver and passengers and it warns that improper vehicle use can result in severe injury or death, seat belts are to be fastened, approved helmets and protective gear are to be worn and cab nets and/or doors are always to be used. The second label also sets out the driver's responsibilities which include the avoidance of abrupt manoeuvres, sideways sliding, skidding or fishtailing. In addition there is a prohibition on performing donuts. The driver is warned to slow down before entering a turn and to avoid hard acceleration when turning. Plans are to be made for hills, rough terrain, ruts and other changes in traction and terrain. Riding across slopes is to be avoided. Drivers are advised to locate and read the owner's manual and follow all instructions and warnings.

Page 17 of the owner's manual provides the following warning in relation to seat belts: "*[r]iding in this vehicle without wearing a seatbelt increases the risk of serious injury in the event of a rollover, loss of control, other accident or sudden stop. Seat belts may reduce the severity of injury in these circumstances.*" A similar warning is given with respect to the use of protective apparel such as an approved helmet and protective eyewear by all passengers.

Page 42 of the owner's manual depicts the correct procedure for operating the ATV as follows:

Driving Procedure

1. Wear a helmet and eye protection.
2. Perform the pre-ride inspection. See page 35.
3. Sit in the driver's seat and fasten the seat belt.
4. Always use the cab nets (or doors) while riding in this vehicle.
5. Start the engine and allow it to warm up.
6. Apply the service brakes and shift the transmission into gear.
7. Check your surroundings and determine your path of travel.
8. Release the park brake.
9. Keeping both hands on the steering wheel, slowly release the brakes and depress the throttle with your right foot to begin driving.
10. Drive slowly. Practice maneuvering and using the throttle and brakes on level surfaces.
11. Do not carry a passenger until you have at least two hours of driving experience with this vehicle.

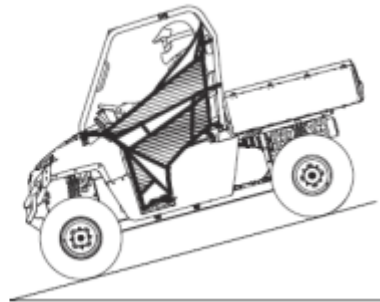


On page 44 of the owner's manual the precautions to be taken when driving downhill are set out as follows:

Driving Downhill

When driving downhill, follow these precautions:

1. Avoid excessively steep hills.
2. Drive straight downhill. Avoid descending a hill at an angle, which would cause the vehicle to lean sharply to one side. Travel straight downhill when possible.
3. Slow down.
4. Apply the brakes *slightly* to aid in slowing.



Further safety advice is provided to the operator on pages 18 and 19 as follows:

Operating at Excessive Speeds

Operating this vehicle at excessive speeds increases the operator's risk of losing control. Always operate at a speed that's appropriate for the terrain, the visibility and operating conditions, your skills and experience and your passengers' skills and experience.

Turning Improperly

Turning improperly could cause loss of traction, loss of control, accident or rollover. Always follow proper procedures for turning as described in this owner's manual. Never turn abruptly or at sharp angles. Never turn at high speeds. Practice turning at slow speeds before attempting to turn at faster speeds.

Descending Hills Improperly

Improperly descending a hill could cause loss of control or rollover. Always follow proper procedures for traveling down hills as described in this owner's manual. See page 44.

Given AB was 14 years of age she was ineligible to hold a driver licence of any class. At the time of the crash she was not wearing an approved helmet and she was not wearing the seatbelt which was provided for the use of the driver.

A thorough examination of the crash scene revealed there were no obvious signs the ATV was under emergency braking at any point prior to the point of impact. In the absence of this evidence the speed of the ATV prior to the collision could not be calculated. In addition the ATV was not fitted with any device capable of recording pre-or post crash data.

As a result of his investigation Senior Constable Morris is of the opinion the evidence at the crash scene is consistent with the ATV performing figures of eight and circle work around obstacles on the property. AB has died as result of losing control of the ATV which has caused it to dig into the surface and that has resulted in her being ejected due to the rotation of the vehicle and her not wearing a seatbelt.

Senior Constable Morris' opinion was peer-reviewed by Senior Constable Kelly Cordwell who is a very senior and experienced crash investigator. She has indicated she is satisfied Senior Constable Morris' opinion is balanced and factual and his opinions are supported by the evidence which has been gathered. I accept Senior Constable Morris' opinion.

On 15 February 2023 Dr Donald Ritchey performed an autopsy. Following that autopsy he provided a report in which he expressed the opinion that the cause of AB 's death was blunt trauma of the chest arising out of the crash of the ATV. The chest injuries were severe and included multiple bilateral rib fractures, collapsed lungs with lung bruising and large volume bleeding into the pleural spaces. He says although the precise mechanism of injury is unclear impact with the ground is suspected to have caused the chest injuries. Because the fatal injuries were confined to the chest he says *"it seems evident that these injuries would not have occurred if properly fitted seatbelts were worn."* The mechanism of death was hypovolemic shock. I accept Dr Ritchey's opinion.

An analysis of samples taken at autopsy confirmed AB had no alcohol or illicit drugs in her blood.

EL and her mother say they knew prior to the crash they were going to a farm near Bridgewater and EL says she knew AB was going to be driving the ATV and that her mother knew they were going to the farm. AB 's parents, KW and SE, say they were not aware AB was going to HD's property that day and if she had asked KW says he would not have given permission. SE says she was not aware AB was intending to drive HD's ATV and had she known she would not have allowed her to undertake that activity because she thinks it was unsafe for her to do so.

SE says it is important to her that the issue of whether she knew that AB was going to HD's farm on the day of the accident be factually determined. Ordinarily that would be done by testing the evidence at a public inquest. While I accept that it is an important issue to SE its

resolution does not alter in any way the findings, comments and recommendations I might make under s28. Those statutory duties can be discharged by considering the evidence set out in the documents on pages one and two without the need to proceed to a public inquest. Further if I was to hold a public inquest that would necessarily involve EL giving evidence. She was 14 at the time of the crash and she is now probably 15. Not only was she involved in a very traumatic accident in which she was injured she also stayed with AB and provided her CPR, under instruction from emergency services, prior to the arrival of officers from AT. In addition AB's death is not one referred to in s24(1) of the Act and the investigation reveals there are no suspicious circumstances surrounding her death. Finally an inquest is unlikely to reveal any additional, significant information about AB's death. After taking all those matters into account I have determined it is not necessary or desirable in the interests of justice to hold an inquest.

Comments and Recommendations

I am satisfied alcohol and drugs played no role in the crash which claimed AB's life. Although the ATV was in poor condition there is no evidence that any of the defects contributed to the crash and there is no evidence of any catastrophic failure being causative of the crash. There is no evidence to suggest the involvement of any other person in her death and the weather conditions did not cause or contribute to the occurrence of the crash.

I am satisfied from the evidence that the ATV was driven at a speed, on a slope and over rough terrain which, owing to AB's inexperience as a driver, resulted in her losing control. As a result of this she has been ejected from the cabin thereby sustaining fatal injuries.

The single most important factor which caused death was the failure of AB to wear a seatbelt. If she had worn a seatbelt she would not have been ejected from the vehicle. She would have remained within the cabin of the ATV and she would have been protected by it.

Similarly, had cab nets or doors (something expressly recommended for use in the operator's manual of the ATV) been in place AB would not have been thrown from the cabin and therefore she probably would not have sustained fatal injuries.

The circumstances of AB's death require me to **recommend** pursuant to s28 of the Act that ATVs only be operated in accordance with the operator's manual, particularly in regard to the wearing of seatbelts and the use of cage nets and/or doors.

For a number of years coroners in Australia have investigated many deaths associated with the use of ATVs or quad bikes. These vehicles have a tendency to tip or rollover when moving at speed, on rough terrain or across inclines. The rider or driver, having little protection, may

be crushed under the vehicle when thrown from it or suffer fatal or serious injuries after being ejected. In Tasmania Coroner Simon Cooper handed down very comprehensive findings after an inquest into seven quad bike related deaths in 2017.⁵ Those findings contained eight recommendations directed towards reducing further injuries and deaths. Two of those findings are relevant to the circumstances of this case and are in the following terms:

*“I **recommend** consideration be given by the Tasmanian Law Reform Institute and the Attorney-General to the introduction of legislation requiring mandatory training and licensing of all persons using quad bikes.*

*I **recommend** urgent consideration be given by the Tasmanian Law Reform Institute and the Attorney-General to the introduction of legislation that:*

- a) prohibits children under the age of 16 from operating adult size quad bikes;*
- b) prohibits children between the ages of 6 and 16 from operating “youth size” quad bikes other than in accordance with what is specified by the manufacturers to be the appropriate minimum age for such vehicle; and*
- c) prohibits children under the age of 6 from ever operating any quad bike in any circumstances whatsoever.”*

These recommendations are equally appropriate to ATVs such as the vehicle driven by AB in this case. Both a warning sticker on the dash of the ATV and the manual stipulate operators are to be 16 years of age or older and have a valid driver licence.

Enquiries as to whether these recommendations have been acted upon determined that in the 2019/2020 State Budget the Government allocated \$700,000 to fund a campaign to promote the improvement of quad bike safety in Tasmania. It appears the intention was for the Department of Justice (DoJ) to “work with stakeholders on a package of regulatory or other measures to enforce compliance with safety measures in the use of quadbikes...” which measures included a number of Coroner Cooper’s recommendations⁶. Further enquiries were made of the DoJ and a response was received from the Secretary on 10 April 2024. The Secretary advised the funding was split across two DoJ outputs namely Worksafe Tasmania (WT) and Consumer and Building and Occupational Services (CBOS). The funding of \$700,000 was allocated from retained revenue held by WS and CBOS. It was broadly allocated as follows:

⁵ See Heather Dawn Richardson, Jan Severin Jensen, Kendall Russell Bonney, Vicki Mavis Percy, Jay Randall Forsyth, Jacob Graham Greene and Roger Maxwell Lerner [2017] TASCDC 329, 330, 331, 332, 333, 334 and 335.

⁶ See <https://www.treasury.tas.gov.au/Documents/2019-20-Budget-Paper-No-2-Volume-1.pdf> at page 140.

- \$500,000 for a grant program to reimburse quad bike users for expenditure incurred when purchasing and installing safety equipment for their quad bikes and
- \$200,000 for an educational campaign.

Funding was used as intended however few grant requests were received with only \$105,051 being approved for payment to quad bike users over 3 years from 2019/2020 to 2021/2022, \$8182 was spent on processing grant payments and \$244,641 was spent on the education campaign. The total amount spent was therefore \$357,874.

The Government, as part of the 2021/2022 State Budget, allocated \$2 million over four years from 2021 – 2022 to the Primary Producer Safety Rebate Scheme. This scheme provided cashback rebates to farmers who implemented safety enhancements to quad bikes in order to reduce work-related injuries and deaths in farming. I was advised the scheme was particularly popular and ended three years earlier than originally planned on 30 June 2022 with total payments amounting to \$3.602 million which was \$1.602 million in excess of the original funding allocation. Under the scheme 62 rebates were paid for purchases to improve quad bike safety on farms and an additional seven rebates were paid for approved training courses.

My own research has uncovered the following:

- (a) In a paper published by the Royal Australasian College of Surgeons (RACS) prior to the March 2018 State election concern was expressed about the increasing number of deaths and major injuries as a result of quad bike use and that Tasmanian trauma surgeons who manage these injuries on a far too regular basis were acutely aware of the inherent dangers of quad bikes. They had advocated for quad bike safety for many decades and their position included:

“Increasing rider awareness of risks

- *RACS believes that quad bikes and children do not mix.*
- *RACS urges the Australian and New Zealand governments to consider all available strategies to prohibit children under the age of 16 from riding adult quad bikes.*
- *Quad bike handling training should be mandatory for all new owners and users of quad bikes.*

Greater rider protection

- *RACS recommends that riders wear helmets.*

- *There is a common need for improved stability, dynamic handling and rollover crashworthiness safety for both workplace and recreational quad bikes.*"

(b) The 2019/20 annual report of the DoJ says:

"The Department ran a \$700,000 campaign to promote the improvement of quad bike safety in Tasmania. This included extending the Safe Farming Tasmania Program to include a workplace safety rebate to encourage farmers to install roll-over and crush protection devices on quad bikes; a public safety awareness and educational campaign using traditional and social media; the development of a consumer Code of Practice under the Australian Consumer Law (Tasmania) Act 2010 requiring sellers and resellers of quad bikes in Tasmania to provide consumers with safety information prior to purchase; and working with stakeholders to enforce compliance with safety measures in the use of quad bikes".⁷

(c) The website of CBOS, a division of the DOJ, provides the following information:

"The Consumer Goods (Quad Bikes) Safety Standard 2019 came into effect on 11 October 2019. The purpose of the standard is to prevent or reduce the risk of fatality or injury associated with the use of quad bikes.

From 11 October 2020, all new and imported second-hand quad bikes (including general use, sports, transition and youth models) are required to:

- *meet the specified requirements of the United States (US) standard for quad bikes, ANSI/SVIA 1-2017 or the European (EN) standard for quad bikes, EN 15997:2011;*
- *have a rollover warning label affixed so that when the quad bike is used, it will be clearly visible and legible;*
- *provide information in the owner's manual or information handbook on the risk of rollover;*
- *be tested for lateral static stability and display the angle at which the quad bike tips on to two wheels on a hang tag; and*
- *have a spark arrester that conforms to the Australian Standard AS 1019-2000 or the US Standard 5100-1d.*

⁷ At page 20.

From 1 October 2021 (stage 2), all new and second-hand imported general use quad bikes are required to:

- be fitted with an operator protection device (OPD) or have one integrated into its design and to meet the minimum stability requirements of:
- lateral roll stability – a minimum tilt table ratio (TTR) of 0.55 (must not tip on two wheels on a slope less than 28.81 degrees); and
- front and rear longitudinal pitch stability – a minimum tilt table ratio (TTR) of 0.8 (must not tip on two wheels on a slope less than 38.65 degrees).

Fines and penalties may apply for failure to comply with a mandatory safety or information standard.

Consumers and businesses can make a complaint to the Australian Competition and Consumer Commission (ACCC) if they believe they have seen a quad bike offered for sale or have been sold a quad bike that does not comply with the requirements of the safety standard.

Contact information for the ACCC and more information on the standard can be found on the [ACCC Product Safety website](#).”

- (d) A press release of 3 July 2020 by the then Minister for Building and Construction says the following:

“The Tasmanian Government is committed to ensuring the safety of quad bike users in the State.

Quad bike accidents can result in serious injury or death, and children are particularly at risk by quad bike use.

I am pleased to announce that our Government has extended its 12-month rebate scheme for the fitting of an approved operator protection device (OPD), which is designed to protect the operator if the vehicle rolls.

The rebate scheme, which was due to end on 30 June 2020, allows farmers to receive a rebate of up to 50 per cent of the purchase price of an approved operation protection device.

Since the scheme was introduced in July 2019, 103 applications have been approved, totalling more than \$54,000.

The scheme will be extended until 10 October 2021, when the mandatory requirement for OPDs on new utility (general purpose) quad bikes under the Australian Consumer Law will come into effect.

All quad bike users should wear helmets, let others know when they intend to use a quad bike, and be aware of uneven terrain and hidden obstacles that can make quad bike use particularly dangerous.

Tasmanians should not allow children under the age of six to ride any quad bike, and should keep children under the age of 16 off adult-sized quad bikes.

The Government strongly urges quad bike users who have not yet done so, to take advantage of this rebate scheme whilst we continue to work to improve quad bike safety for all Tasmanians.” (my emphasis).

- (e) In late 2021 the Tasmanian *Work Health and Safety Regulations 2012* were amended, with the introduction of regulation 216A which appears to be designed to improve quad bike safety. Those regulations were replaced in 2022. The current regulation is as follows:

“216A. Restrictions on use of quad bikes

(1) The person with management or control of a quad bike at a workplace must ensure that –

- (a) an approved helmet is available for use with the quad bike; and
- (b) any person using the quad bike has been provided with appropriate training in the use of the quad bike; and
- (c) the quad bike is not used to carry a passenger unless the quad bike is designed to carry a seated passenger.

Penalty: In the case of –

- (a) an individual, a fine not exceeding \$6 000; or
- (b) a body corporate, a fine not exceeding \$30 000.

(2) *A person must not use a quad bike at a workplace unless the person –*

(a) has undertaken appropriate training in the use of the quad bike; and

(b) is using the quad bike consistently with that training; and

(c) is wearing an approved helmet.

Penalty: Fine not exceeding \$6 000.

(3) *A person must not use a quad bike to carry a passenger at a workplace unless the quad bike is designed to carry a seated passenger.*

Penalty: Fine not exceeding \$6 000.

(4) *In this regulation –*

approved helmet *means a helmet that complies with AS 1698, AS/NZS 1698, UN ECE22.05 or any other relevant standard;*

quad bike *means a motor vehicle with 4 wheels that is ridden in the same way as a motor bike.”*

While this regulation requires a person who uses a quad bike to have appropriate training and to wear an approved helmet it is of course only limited to work places and not private properties.

- (f) On 22 December 2021 the *Road Amendment (Quad Bike Rules) 2021* came into force. This statutory rule amended 10 of the in excess of 384 road rules which appear in the *Road Rules 2019*. Those rules are uniform throughout Australia but the quad bike amendments have resulted in Tasmania’s road rules no longer being consistent with the model rules in Australia. Rule 270 requires riders of quad bikes to wear an approved motorbike helmet and Rule 271(5)(D) places an age restriction on passengers in the following terms:

“The rider of a quad bike must not ride with a passenger unless the passenger –

(a) is 6 years old or older; and

(b) keeps both feet on the footrests designed for use by a pillion passenger on the quad bike; and

(c) *keeps at least one hand, while the passenger is seated, on the handrail of the bike, if any.*

Penalty: Fine not exceeding 20 penalty units.”

There is no age restriction placed on the rider.

(g) Quad bike is defined in the Road Rules 2019 in the following terms:

“quad bike means a motor vehicle with 4 wheels that is ridden in the same way as a motor bike;”

The ATV in this case does not meet this definition principally because the driver and his or her two passengers sit side by side in a cabin on a bench seat and the vehicle itself is not straddled like a motorcycle and is steered through the use of a steering wheel not handle bars⁸. It would however meet the definition of motor vehicle which means “a vehicle (other than a motorised scooter) that is built to be propelled by a motor that forms part of the vehicle”. Rule 264 which requires a driver of a motor vehicle to wear a seatbelt would apply and rule 265 with respect to the ages and the types of restraints to be worn by passengers of motor vehicles would also apply. The problem is however Rule 270, with respect to the use of helmets, would not apply. Although rule 271(5D) places an age restriction on passengers on quad bikes that rule does not arguably apply to this vehicle and there is no age restriction placed on the driver or person in charge of the controls of such a vehicle.

(h) I can find no reference on the website of the Tasmanian Law Reform Institute that the recommendations made by Coroner Cooper have been considered by that organisation.

It is clear from what I have set out above there has been reform since Coroner Cooper handed down his decision in 2017 which has improved safety but it is my view that further reforms should be made. There is still no requirement for people to be trained to ride a quad bike or ATV outside of the workplace or be licensed and there are no restrictions placed on the age of the rider or driver of a quad bike or a vehicle such as that used by AB in this case.

I repeat Coroner Cooper’s recommendations set out on page 14 (and that those recommendations be applied to the vehicle used in this case) and that

⁸ See the diagram on page 10.

consideration also be given as to whether the type of vehicle used by AB should be included in the provisions in the Road Rules that apply to quad bikes, given their similarity, or whether they should be separately provided for.

While the Government in its press release in 2020 appears to agree with the age restrictions recommended by Coroner Cooper there has been no legislation passed to give those recommendations the force of law.

I extend my appreciation to investigating officer Senior Constable Jimi Morris for his investigation and report.

I commend the efforts of EL who went to AB's aid prior to the arrival of Ambulance Tasmania personnel.

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

Dated: 15 April 2024 at Hobart in the State of Tasmania.

**Magistrate Robert Webster
Coroner**