QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDING OF INQUEST

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| CITATION: | **Inquest into the deaths of**<br>Michael Wayne LAST<br>Ricky Glenn BLINCO |
| TITLE OF COURT: | **Coroner's Court** |
| JURISDICTION: | Brisbane |
| FILE NO(s): | COR-1540/05(0)<br>COR-0181/07(2) |
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| FINDINGS OF: | Mr Michael Barnes, State Coroner |
| **CATCHWORDS:** | **CORONERS: Inquest, Black Duck Valley, recreational off road motorcycling & 4WDriving, local authorities approval of 4WD parks, WH&S investigation of incidents in 4WD parks** |

**REPRESENTATION:**

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| Counsel Assisting: | Ms Julie Wilson |
| Black Duck Valley 4WD park Pty Ltd: | Mr Andrew Diete (owner) |
| Family of Mr Blinco: | Ms Angela Blinco (sister) |

**Findings into the deaths of Michael Wayne Last & Ricky Glenn Blinco**

*Between 2 January 2005 and 16 January 2007, three men were killed in separate incidents at Black Duck Valley Four Wheel Drive and Motorbike Park (BDV) at East Haldon near Gatton.*

*Steven Binns was an experienced motor cycle and quad bike rider. He died having sustained injuries at the Park on 2 January 2005 after executing a jump and coming to a heavy landing on a quad bike circuit. Findings were delivered by Coroner G M McIntyre on 15 June 2005, before the other two deaths. The cause and circumstances of Mr Binn's death were outside the scope of this inquest. However, the safety and risk management policies and procedures in place at Black Duck Valley at the time of Mr Binns' death and thereafter were considered at the inquest.*

*Michael Wayne Last died on 25 June 2005 while attempting a high speed, long distance motorcycle jump launched from a five metre high steel ramp. Ricky Blinco died at BDV on 16 January 2007 after he lost control of his Toyota Landcruiser while traversing a four wheel drive track. Mr Blinco was thrown from his vehicle and sustained fatal injuries.*

*The circumstances of these two deaths were investigated by this inquest with a view to determining whether changes to the regulation of such facilities and/or changes to the way BDV is managed would reduce the likelihood of future deaths.*

The *Coroners Act 2003* provides in s45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system or other agencies with responsibility for the areas of administration referred to in any comments or recommendations. These are my findings in relation to the death of Michael Wayne Last and Ricky Glenn Blinco. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

# The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

## *The basis of the jurisdiction*

Because both deaths were sudden and unnatural they were reported to the Toowoomba coroner in accordance with the requirements of s8(2)(a) and (3)(b) of the Act. When it became apparent that three deaths had occurred in short succession at the same facility it was decided by me that an inquest was

necessary and I assumed responsibility for these matters. The Act provides a number of deaths that occur at different times and places can be investigated at the same inquest.[1] The similarity of the issues raised by the death of Mr Last and Mr Blinco made this appropriate.

## *The scope of a Coroner's inquiry and findings*

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [2]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3]

A coroner must not include in the findings or any comments or recommendations statements that a person is or may be guilty of an offence or civilly liable for something.[4] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[5]

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[1] s33
[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46
[4] s45(5) and 46(3)
[5] s48

### *The admissibility of evidence and the standard of proof*

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation. However, in *R v Tennent; ex parte Jager*[11] the Supreme Court of Tasmania held that this obligation did not extend to hearing submissions for the subject of a potential referral to the DPP prior to such a referral being made.

## The investigation

Both deaths were investigated by police officers from Gatton Station with qualification in traffic accident investigation. They took photographs and measurements of the scene and interviewed witnesses. Both vehicles were inspected by QPS mechanical inspectors.

Officers from the Division of Workplace Health and Safety also attended the scenes of both accidents and undertook some investigation.

In relation to the death of Mr Last, a Workplace Health and Safety inspector took measurements and photographs of the ramp jump and interviewed various people. As a result she concluded that the operators may have been

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[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168
[11] (2000) 9 Tas R 111

in contravention of section 28 of the *Workplace Health and Safety Act 1995* and issued an improvement notice requiring the jump to be assessed by a competent person to certify that it had been appropriately designed and installed. It was not able to be used until this was done. The operators provided the Division with a statement from the designer and manufacturer and a number of local motocross competitors who had used the site. The seizure notice that had been served at the same time as the improvement notice was then withdrawn and no further action taken.

The officers of the division took minimal action in relation to the death of Mr Blinco. An inspector went to the scene of the accident and spoke to some of the witnesses. Despite the provisions of section 28 of the *Workplace Health and Safety Act 1995* clearly placing an obligation on those who conduct a business to do so in a way that "*any other persons*" are not adversely effected, the Division came to the view that the Act did not apply to the circumstances of Mr Blinco's death because he knowingly took part in a high risk activity. The Division concluded that this was a public safety issue as opposed to a workplace health and safety matter. Accordingly, the division concluded that Mr Blinco's death fell outside its investigative jurisdiction.

This office commissioned reports from a number of independent experts. I was particularly assisted by the opinions of Professor Rod Troutbeck, an eminent academic and engineer with significant experience in safety systems in motor sports and Mr George Foessel a former police investigator and trainer who has since established a private 4WD driver training school. Those gentlemen attended at the scene of these deaths prior to compiling their reports.

## The inquest

A pre-inquest conference into both deaths was conjointly convened on 19 March 2008. Ms Wilson was appointed counsel assisting. An issues list was distributed and a tentative list of witnesses discussed. The matters were then adjourned for hearing on 14 April 2008 where they proceeded over four days. When the inquest commenced, leave to appear was granted to Mr Andrew Diete on behalf of the operator of Black Duck Valley and Ms Angela Blinco the sister of Ricky Blinco. Ninety-Five exhibits were tendered and 28 witnesses gave evidence.

The two independent experts referred to earlier who provided reports, also gave evidence as did Mr Malcolm Grange, the CEO of Motorcycles Queensland concerning the regulation of sports motorcycling and Mr Murray Morris, an office bearer of 4WD Queensland.

At the close of evidence, counsel assisting and Mr Diete provided me with written submissions on the findings I might make. I found them to be of great assistance.

# The evidence

## *Black Duck Valley*

Various members of the extended Diete family have farmed land around that on which BDV is now operated for over 50 years. Progressively, since 1986 farming has been diminishing and the use of the land for recreational driving has expanded.

At first, old stock and fire trails were expanded to accommodate four wheel drive clubs whose members were experienced and equipped to handle the very rough terrain. The tracks were originally graded for difficulty by 4WD Queensland in the early 1990s and a map showing these gradings and explaining the levels of experience needed was prepared.

The Gatton Shire Council issued a 'consent approval' pursuant to the *Planning and Environment Act* in 1995 to authorise the land being used for this purpose. A material change of use of the land was approved under the current legislation (*Integrated Planning Act* 1997) in 2003 as more land was brought into the operation of the park and other facilities were added.

Initially, the park attracted mostly 4WD clubs and driver trainers. This meant that the driver's were largely experienced or in the company of experienced drivers. The clientele changed in recent years with the growing popularity of the motorcycling facilities. Now the park attracts mainly individuals or smaller private groups. In the main, the park operators know nothing about the experience or expertise of these users. With the addition of a number of motocross tracks and a motorcycle freestyle area with ramp jumps, the main focus of the park is on these activities with less attention and patronage of the 4WD tracks.

## *The death of Michael Last*

### Background

Michael Last was born 27 March 1970. He was 35 years old at the time of his death. He had two young children, Damon and Amy.

Michael and his brother Malcolm had been riding motorcycles since they were approximately 10 years old. Malcolm gave evidence at the inquest and said that he and Michael did a lot of motorcycling in their youth.

Mr Last stopped riding when his first child was born 10 to 11 years prior to his death. He had recommenced motocross riding about 18 months prior to the accident.

Although experienced dirt and bush riders, Malcolm Last describes he and his brother as novices with respect to jumps. In fact, neither of the men had ever attempted a ramp jump, as distinct from dirt jumps on motocross tracks, before the day of Mr Last's death.

The Last brothers had been to Black Duck Valley Park on two or three occasions before the weekend of the fatality. At no time was their competence assessed or inquired into. They were not asked to produce any license or other evidence of their ability to ride the motor bikes they had brought with them. They were told of the need to always wear helmets when riding and to comply with the rules of the park which were printed on the form they signed, a copy of which was given to them. On each occasion they were required to sign a waiver releasing the operators of the park from any legal liability that might flow as a result of injury to the park users or their property.

## The circumstances of the death

Mr Last was at Black Duck Valley on 25 June 2005 for the purpose of recreational motocross riding. He was there with Malcolm Last, Lauren Vincent, and his children Damon and Amy. The group had four motorcycles and quad bikes with them. Mr Last was riding a Yamaha YZ450F 2003 model motorcycle. They arrived at the park at about 8.00am. They were told about the freestyle area which contained the ramp jumps. It had been opened since their last visit. They were told they were free to use the area.

At about 10.00am, Michael and Malcolm went to look at the ramp jumps in the freestyle area of the park. There are four of these installed in this area and there is no restriction on access to them. The brothers were interested in trying a jump known as the world record jump or the long distance jump that they had heard of from other users.

Initially, Michael and Malcolm went over the ramp jump slowly; at not more than 40km/hr according to Malcolm's evidence at the inquest, in order to "*get the feel of the jump*." They then increased their speed until Malcolm was hitting the ramp at a top speed of 80 – 90 km/hr. His brother Michael had a much more powerful bike and another witness estimated his speed on the ramp to be in the vicinity of 120km/hr. Malcolm estimates that they each executed the jump between 15 to 20 times prior to the fatal incident.

James Dick observed the Last brothers tackling the jump and noticed that on a number of occasions Michael landed on his front wheel. Another witness, Jean Morel, also had an opportunity to observe Mr Last execute the jump a number of times before the incident. He was of the view that Mr Last did not know how to give the bike sufficient speed with the correct amount of 'revs' either on the approach or in the air.

A number of people observed Michael Last attempt what transpired to be his last jump. Mr Morel says that he saw the bike travelling down the runway at a speed he estimated to be 120 km/hr – "*as fast as it could go*." He said that as the bike left the ramp its engine was "*revving*" highly but then its "*rev limiter*" cut in and the engine returned to an idle. He says he saw Mr Last's bike almost vertical in the air with the front wheel high. He lost sight of it as it went over the ramp and was obscured by the table top and landing ramp.

Malcolm's bike was malfunctioning in a manner that required him to have breaks in order to allow the engine to cool. At about 2.30pm he was in a spectator's area adjacent to a tabletop landing area near the point where riders executing the jump land. He was waiting for Michael to finish riding as the group had decided to leave the park shortly.

Malcolm heard his brother's bike approach the ramp and saw him coming over the end of the ramp. Malcolm Last could tell at that point that something was wrong since the front of Michael's bike was too low. That indicated that the bike would land front wheel first. Malcolm's evidence is that he knew that there was about to be serious accident that would result in serious injury or death.

The front wheel of the bike did connect with the track approximately 10 feet from where Malcolm was standing. He saw his brother hit the ground head first and the bike then tumbled onto him. The bike cartwheeled down the decline and Michael slid along the ground for a further 20 feet.

Malcolm called for help and asked a bystander to call an ambulance. Andrew Diete arrived at the scene soon after and he, along with Mr Dick, performed CPR.

QAS were called to attend the scene at about 2.40pm by Andrew Diete. He used an earth mover to clear a path for the ambulance which arrived on the scene at 3.06pm. Mr Andrew Diete and Mr Dick were still performing CPR. Advanced Care Paramedic Gordon noticed serious head injuries and that Mr Last was asystole.

The QAS communication centre activated the Rescue 500 helicopter which arrived on the scene at 3.15pm. Adrenalin was administered. Resuscitation attempts ceased at 3.37pm as those present concluded Mr Last's injuries were non survivable and he could not be revived. He was pronounced dead. Malcolm Last identified Michael Last's body to police who arrived soon after the ambulance.

## Post death investigations

The investigations described earlier then commenced.

The inspection of the motor cycle revealed nothing that could have contributed to it crashing.

An autopsy was conducted on the body of Mr Last by Dr Guard on 27 June 2005. In his opinion the medical cause of death was

1 (a) Multiple neuronal shearing stresses with bilateral subarachnoid haemorrhages due to;

(b) Multiple comminuted fractures of the skull

2 Fractures of mandible, maxilla and T4/T5 with crushing vertabra

## *Findings required by s45*

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

**Identity of the deceased** – The deceased person was Michael Wayne Last

**Place of death** – He died at Black Duck Valley 4WD and motorcycle park near Gatton, Queensland

**Date of death** – Mr Last died on 25 June 2005

**Cause of death** – He died from head injuries sustained in a motorcycle crash

## *The death of Ricky Blinco*

### Background

Ricky Blinco was 23 years old at the time of his death. His family and friends expressed to the Court their love for a young man who was a hard worker and good friend. Ricky was working as boilermaker building draglines in the mining industry, had recently purchased his first home and had high hopes for the future. Mr Blinco clearly had a great enthusiasm for life, his friends and very close family.

Mr Blinco had owned a 4WD for a number of years and had used it off road on numerous occasions but he had never been to BDV before. His friend Nathan Ruoso had been there and he had recently purchased a 4WD. So the two young men decided go together, taking both vehicles with the intention of camping overnight.

### Arrival at BDV

Ricky Blinco and Nathan Ruoso arrived at Black Duck Valley in their separate vehicles at approximately 10.00am on Tuesday 16 January 2007.

On arrival they were required to “sign in.” Katherine Diete was meeting guests for this purpose. There was some conflicting evidence about what exactly was

said during this meeting. Mr Ruoso admitted that he did not have a clear memory of all of the conversation. He remembers talking generally about their trip up and where they could camp. He recalls that each of them was given a photo copied trail map and that Mrs Diete pointed out the motocross tracks and the 4WD tracks and drew their attention to the markings indicating the grading of the tracks which were classified as beginner, intermediate and advanced tracks. He agrees that they were required to sign a waiver purporting to release the operators from all legal liability.

He also recalls being told that there was a track "*up the back*" that was not suitable to be traversed. It is clear that this was not a reference to 75, the scene of the fatal accident as Mrs Diete conceded that she believed that was closed and she would therefore have made no mention of it. Further, it did not appear on the map the guests were given.

Mrs Diete says that she also told them that the advanced tracks were very demanding; using words to the effect that they "*can be quite murderous*" and "*extra things like winches*" might be required. Mr Ruoso does not remember this but accepts that's he understood that the advanced tracks were obviously more demanding and would require more skill to negotiate than the beginner or intermediate tracks. He denies there was any mention of additional equipment being required and points out that their vehicles were in plain view during the discussion. All agree there was no discussion about the level of the men's expertise or experience of four wheel driving.

The UHF channel to be used was not printed on the map provided to Mr Blinco and Mr Ruoso. Mr Ruoso's says that he must have been told which channel to use because the two men communicated via the radio as they were negotiating the park prior to the accident.

Mr Ruoso's evidence was that Mrs Diete spent approximately 15 minutes with him and/or Mr Blinco. The two men were not always in each other's presence during that period.

## The circumstances surrounding his death

The two men drove into the park along what is called the Tojo track, a reasonably benign and well graded track that circles the park and from which smaller and more difficult tracks branch. They were orientating themselves before selecting a place to camp. They followed that route for about 40 minutes before stopping at the bottom of track 33, which was shown as an advanced track on their map, but according to Mr Andrew Diete, was signposted as intermediate.

Mr Ruoso's evidence was that he had a drink of Powerade at that time. He can't recall if Mr Blinco retrieved a drink from the esky but was adamant that he did not see Mr Blinco drink any alcohol that morning.

Mr Ruoso decided that he did not want to attempt an advanced track as he was less experienced and was more concerned about his recently acquired vehicle. He told Mr Blinco that he would meet him at the exit point of the track.

Mr Ruoso waited in his vehicle at the intersection of the Tojo track and track 33 while Mr Blinco proceeded up the hill. The two communicated by UHF radio. He recalls Mr Blinco saying that the track looked as if it had not been used. That prompted Mr Ruoso to check the map and he confirmed that Ricky was on the right track, although this was largely speculation as track 33 disappeared off the edge of their maps.

At one stage Mr Blinco said words to the effect that "*it's a bit of a wild ride, you'd be glad that you didn't have a go at the track, but she'll be right*."

After some time, perhaps 15 minutes, Mr Ruoso proceeded along the Tojo track to the point at which he thought Mr Blinco would rejoin it after having completed the more advanced track. This was shown on the map as point 118 on the Tojo track and as the intersection of that track and another marked track 91. Mr Ruoso and Mr Blinco continued to talk over the radio and then the radio went silent. Before it did, Mr Ruoso heard Ricky say "*this wasn't a good idea*." Mr Rouso could see the track Ricky had taken climbed steeply above the Tojo track and that he would need to descend to rejoin that tack and so he told Ricky to take a downhill course when he had an opportunity to. It seems that acting on this advice, Mr Blinco took track 75 which branched to the right and downwards from track 33. It seems that it had a symbol indicating that it was an advanced track

Mr Ruoso continued trying to contact his friend by radio but when he received no response he decided to investigate on foot.

He walked up track 91. After climbing several hundred metres, he saw in the distance, at the bottom of a cliff and a long way from the track, what he thought was a vehicle, He made his way to it cross country and confirmed that it was Ricky's badly mangled 4WD. He saw that it was unoccupied and that there was blood on the dashboard. He fervently hoped that Ricky had been injured but was well enough to have removed himself from the scene. A brief exploration of the surrounding bush snuffed out this optimism when he found Ricky's obviously dead body some 30 or 40 metres higher up the hill.

## Post death events

Mr Ruoso frantically returned to his vehicle and tried without success to make contact with the BDV operators using the UHF radio. He drove back towards the main entrance and came across another party who accompanied him back to the scene of the crash.

They quickly confirmed that Mr Blinco was dead and went to inform the authorities.

Police arrived at the park at about 2.40pm. They were handed a map by one of the Diete family. One officer gave evidence that he recalls it containing handwriting including a notation that track 75 was closed but it is clear that there was no sign to that effect on the track and neither Mr Blinco nor Mr Ruoso were told that was the case.

The officers were driven to the scene by State Emergency Services personnel. Sergeant McDonald described the Tojo track as well maintained but challenging. He said that in his opinion track 75 was very dangerous and difficult to walk. The track was eroded and there were vertical drop-offs which he pointed to in photographs taken during the course of the investigation.

Sergeant McDonald also said that he had considerable difficulty contacting police communications in order to arrange retrieval of Mr Blinco's body. A satellite phone was ultimately obtained but communication remained difficult. Lack of availability of helicopter rescue services added to the delay in moving Mr Blinco.

At approximately 6.00pm an Energex helicopter arrived at the scene and Mr Blinco's body was winched up to it. The pilot had difficulty finding the arranged location to transfer Mr Blinco to the undertaker and had another urgent job to attend to, so set Mr Blinco's body down in a paddock from where it was collected at about 6.45pm. The body was taken to the morgue at Toowoomba and arrived there at about 8.00pm. [12]

It is concerning that Mr Blinco's family were not notified of his death until approximately 6.20pm.

Dr Guard performed an autopsy examination on Mr Blinco's body on 22 January 2007. It had undergone significant decomposition on account of the time spent outdoors in the heat of the January weather.

He concluded that the cause of death was –

1 (a) Shock from anoxia; due to
(b) Multiple fractures of the ribs, sternum, spine (2 places) and bilateral fractures of femurs plus head injury due to;
(c) Trauma from MVA

And listed other significant conditions as:-

2 Gross obesity
Under the influence of alcohol at the time of death

Further comment is warranted in relation to Dr Guard's finding concerning alcohol. Toxicology testing on a post mortem blood sample revealed an alcohol concentration of 109mg/100mL (or 0.109%). Dr Guard's evidence was that although alcohol can be produced by the body during the decomposition process, this is unlikely to produce in excess of 50mg/100mL (0.05%). He was unable to say in what circumstances the body might produce a higher concentration of alcohol post mortem. However, evidence

[12] I only became aware of the mix up concerning the transfer of Mr Blinco's body from the helicopter to the hearse during the course of the inquest. Little would be achieved by inquiring into that now but it is obviously unacceptable and inappropriate that a body be treated in that way.

from Professor Olaf Drummer, a forensic pharmacologist and toxicologist, challenged this view. In his opinion it was quite possible for the fermentation process which occurs during decomposition to produce alcohol in excess of 100mg/100mL.

Mr Ruoso gave evidence about this possibility of Mr Blinco drinking and indeed he was recalled to give further evidence in relation to it. He appeared to me to be a truthful witness: he readily admitted when he could not remember details and was prepared to concede that he may have been mistaken about some things. He was adamant that he did not see Mr Blinco drinking on the day of his death and saw no indication that he was in any way affected by alcohol. Mr Blinco made no comments that would suggest he had consumed an alcoholic beverage. Therefore in the absence of any evidence that Mr Blinco had been drinking alcohol on the morning of his death, I conclude that the alcohol found in his blood was a post mortems artefact.

A mechanical examination of Mr Blinco's vehicle was hampered by the extent of the damage done by the crash. However, an examination of it was still undertaken and the mechanic who did so noted that the right rear outer brake pad was very worn. However he also indicated that "*this defect was not serious enough to affect the safe operation of the vehicle under normal operating conditions."* When he gave evidence at the inquest, the mechanic said that he was satisfied that nothing about the condition of the vehicle, including the brakes contributed to the crash.

Having regard to the photographic evidence and the views of the experts who attended the scene, I consider the likely sequence of events leading to the crash is as follows. A couple of hundred metres after the commencement of track 75, the gradient very substantially increases – estimated by Mr Foessel to be approximately 25 degrees. The track is extremely rough with many loose boulders and washouts creating some almost vertical drops of between 80 cm and 120 cm.

The tyre tracks give no indication of any excessive speed but support the conclusion that the track's condition was the main precipitator of the driver losing control of the vehicle.

Mr Foessel and the police investigators suggest that Mr Blinco attempted to use a well known technique to prevent damage to the undercarriage of his vehicle by straddling the very deep ruts in the track.

It appears that the vehicle skidded and after lurching over a vertical drop in the track of approximately 80cm it rolled over before hitting a tree. It seems to have landed back upright but had gathered momentum and Mr Blinco was unable to prevent the vehicle bouncing from the track and careering across a wide steep slope that led to a cliff. Police accident investigator Constable Watts noted marks on the slope preceding the cliff that suggest that Mr Blinco attempted to brake and swerve to avoid going over the cliff. It is apparent he was unsuccessful and from that point a fatal conclusion was inevitable. The hand brake was found to be partly on; Mr Blinco may have tried to use it to

slow the vehicle. He was not wearing a seat belt and seems to have been thrown through the windscreen as the car crashed down the cliff. It is almost certain that he was by then unconscious and he would have died very soon after without regaining consciousness.

### *Findings required by s45*

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

**Identity of the deceased** – The deceased person was Ricky Glenn Blinco

**Place of death** – He died at Black Duck Valley Park near Gatton, Queensland

**Date of death** – Mr Blinco died on 16 January 2007

**Cause of death** – He died from multiple injuries sustained in a motor vehicle crash

## Concerns, comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I am of the view that both of these deaths were preventable and that the continued operation of Black Duck Valley in the manner in which it has been operating poses a danger to public health and safety and creates a risk of further deaths occurring in similar circumstances.

These concerns are borne out by an examination of the facilities on which the deaths occurred and consideration of the management practices, or culture, as one witness described it, of the operators. I will deal with each of those issues in turn but before I do I want to convey my sincere condolences to the families and friends of Mr Last, Mr Blinco and Mr Binns. They were all young men with close families who were making a significant contribution to the community. I know they will be sorely missed by many.

And second, I want to observe that these deaths were not unforeseeable, isolated events. Rather data provided by the Toowoomba Hospital makes clear that serious accidents occur at BDV very regularly. Hospital staff became so concerned by the frequency and seriousness of the trauma cases they were dealing with from the park that they began collecting statistics. The

nurse manger for the Toowoomba Hospital Emergency Department told the inquest that between June 2005 and April of this year 285 patients had required treatment from either that hospital or Gatton. The nature of the injuries was also of concern: some life threatening; many long bone fractures in young people with a potential for long term disability. An ambulance officer from Gatton advised that they have had to roster extra staff on weekends to meet the demand from BDV and frequently have to rely on units from other centres to respond to Gatton matters because the Gatton unit is tied up attending to BDV cases.

In 2005, two meetings were held as a result of these concerns. Senior officers from Queensland Health, the Police Service, the QAS and the local Member of Parliament, Mr Ian Rickuss attended. They resolved to correspond with the Gatton Shire Council and other agencies that may have had jurisdiction to intervene. Despite the best intentions of those involved it seems little changed as a result of this initiative.

In August 2005, the same concerns led the Gatton Shire Council, to write to the Division of Workplace Health and Safety to express its apprehension about the safety of users of BDV facilities and the impact these incidents were having on local emergency services. The local regional manager of WH&S responded advising of the doubts concerning the division's jurisdiction to inquire into such matters but confirming that the death of Mr Last would be investigated. As detailed above, a different conclusion was reached when the division considered whether it would investigate Mr Blinco's death and so far as I can ascertain the division has not investigated any of the numerous injury accidents that have occurred at the park.

It seems clear these expressions of concern from responsible members of the community have not caused the operators of BDV to improve their practices: media reports indicate that just last weekend a further seven visitors to the park required ambulance attention.

I turn now to the factors identified earlier as contributing to these serious personal injuries and public health concerns.

## *Problems with the jump*

The ramp jump on which Mr Last was killed was designed and built for a "one off" world record long distance jump attempt. It was intended to be used at a one day event supervised by specialist marshals, attended by advanced para medics and ridden over by a highly experienced and very competent professional motorcyclist.

After the world record attempt, the ramp was moved to Black Duck Valley. It was installed by members of the Diete family against a hillside which had been excavated for that purpose. Installation was by trial and error with members of the family testing the jump throughout that process. The ramp designer was not consulted. Anyone who attended the park was then free to use it without any regard to their ability or experience. It was anticipated that they would launch themselves off the ramp at speeds of up to 120 km/hr in

circumstances where they could not see the landing area, travel through the air for up to 150 feet before landing on an earthen table top or down ramp. No or minimal supervision of users was provided.

The designer, Mr Kirk, and the independent experts, Mr Foessel and Professor Troutbeck, all gave evidence about flaws in the set up of the ramp and the dangers they created.

Mr Granger of Motorcycling Queensland said in evidence that "*the jump was clearly not built for amateurs or beginners*." He said that riders should have to demonstrate some competency before using it. Dion Kirk agreed.

In the statement provided to Workplace Health and Safety investigators Mr Granger said –

> *This long distance ramp jump…should not be attempted by anybody without the competence required and this competence is usually demonstrated by holding the appropriate licensing with supercross or freestyle endorsement though Motorcycling Australia*."

Mr Granger's evidence was that given the degree of technical skill required to execute a jump of this nature safely, or with minimum risk, a rider must demonstrate "*an extremely high level of competence*" which clearly Mr Last could not, given he had never before that day attempted any ramp jump. Mr Granger suggests that the jump be secured in such a way that restricts access to those who can demonstrate their skill by licence and/or endorsement and even then, the jump should be constantly supervised.

Professor Troutbeck and George Foessel agree with Mr Granger. Both experts recommended that use of the ramp be restricted to members of the public who hold the appropriate endorsement from Motorcycling Queensland.

## *Problems with the track*

George Foessel opined that track 75 should not have been open to or used by the public. He described it as unpassable and said even with his expertise and experience he would not attempt it. Track 75 had not been inspected for at least two years. The signs marking its number and classification were obscured by foliage. It had become significantly eroded to the point where it contained vertical drop offs that were bound to have a destabilising effect on a vehicle traversing it. By the time Mr Blinco drove down track 75 on 16 January 2007 it was so dangerous that an experienced driver in a standard vehicle could not expect to traverse it successfully. Yet anyone who paid admission to the park was free to use it without any warning of the likely consequences.

## *Problems with the management of the park*

Many of the activities engaged in by visitors to BDV are inherently dangerous. That doesn't necessarily mean that they should be prohibited because there are obviously many potential social and economic benefits of such activities.

They provide an opportunity for families and groups of friends to engage in healthy exercise, the park provides a living for the Diete family and employment for members of the local community. There are economic benefits for other businesses involved in selling and servicing vehicles used in the park. Therefore the dangers posed by the activities engaged in at the park do not necessarily mean that it should be closed; rather it simply requires that the risks be adequately managed. Some of the activities engaged in at BDV can not be made risk free; but they can most definitely be made far safer than they are at present.

Alarmingly, Black Duck Valley does not engage in any effective risk management. Andrew Diete's evidence was that the company makes the risks as obvious as possible to members of the public using its facilities and expects those users to avoid those risks. The company considers that risk management is the responsibility of those using the facilities and that "*people should make their own decisions*". As is detailed below, the approach is rendered meaningless by the failure of the operators to provide users with sufficient information to make such decisions.

The only risk the operators seem to have serious regard to is the risk of their being sued. After the death of Mr Last they did not alter the way the long distance jump is set up or used but they revised the waiver designed to protect the operators from civil liability.

Mr Granger of Motorcycling Queensland told the Court that Black Duck Valley has a reputation for allowing people to do "*what they like with whatever machinery*" even if it was unsuitable or the users untrained.

That is unacceptable according to Professor Troutbeck, an expert in risk management in motor sport. Indeed he recommended that "*all activities cease until a full and complete, independent risk assessment be undertaken of all facilities at the Black Duck Valley Park and the results of the risk management plan from the assessment are implemented*."

Some particulars of the dangers and the failures of the operators to adequately respond to them are:-

- **The track maintenance program** is "*ad hoc*" according to Andrew Diete. His evidence was that he inspects tracks on an apparently random basis with a focus on those tracks he likes to ride/drive recreationally. It was clear that some tracks have not been inspected for up to two years or more and the company does not document which tracks have been inspected and when.

- **The classification of the tracks** according to level of difficulty has not been undertaken using any standard or recognised criteria since the early operation of the park some 15 years ago. The information provided about the degree of difficulty is inadequate to enable a user to make an informed decision about whether he or she should attempt to use a track and in

many cases turning back if the track is found to be beyond the safe range of the driver or vehicle will be impossible.

Professor Troutbeck recommends a re-evaluation of the classification of each track as a matter of urgency and in accordance with recognised criteria. Murray Morris of 4WD Queensland gave evidence of and provided that organisation's Track Classification Code. Any track that is assessed to be dangerous to members of the public, driving standard vehicles, should be closed. These are valid suggestions that should be implemented forthwith.

- **The sign-in process is informal and inadequate** to provide users with sufficient information prior to their entering the park. The information given varies depending on whether the user is recognised to be a regular visitor, the person on duty at the front gate knows enough about the park and the level of interest shown by the user in receiving information. Andrew Diete suggested that too much information can be a bad thing. It is all too obvious that insufficient information poses far greater risk. The person who advised Mr Blinco about the tracks was not even aware whether the track where he met his death was open. Users should be told what is meant by the various track classifications.

- **The competence and experience of each visitor should be gauged** against the likely required skill level for each activity before they are given access to those facilities. Currently no inquiry is made even though the evidence indicates that some of the facilities could only be used with an acceptable level of risk by professional competitors.

- **The map of the park is inadequate**. The track marked 33 and advanced on the map given to Mr Blinco's was in fact signposted 32 and intermediate. Track 75 was not marked on the map but clearly available for use by the public once track 32/33 had been traversed.

  The map is a black and white, poor quality photocopy while coloured symbols are used on signs to depict the classification of tracks. Little useful information is given to explain the levels of difficulty used to classify the tracks.

## *Regulation of the activities conducted at Black Duck Valley*

Some of the witnesses who gave evidence, including the operators of the park, seemed to have a philosophical objection to the activities of the park being regulated. They espoused views redolent of primordial liberalism to the effect that if individuals want to engage in dangerous activities they should be allowed to do so, free from government intervention, even if it results in their being killed or injured. In my view, even were this approach morally acceptable, it would have limited application to the activities at BDV because the management inadequacies referred to earlier mean that patrons are not able to make a valid assessment of the likely consequences of using the facilities. It can't be said that they have voluntarily accepted the risks if they

are hidden from them. The exercise of their free will must also be informed if it is to be effective.

However, there are also more fundamental, philosophical reasons for rejecting this approach. One is utilitarian in nature: as the figures quoted earlier demonstrate, the financial cost to the community of providing emergency medical care and hospital admissions is significant. Added to that is the loss of production flowing from the death or injury of workers. It can be persuasively argued that the State is entitled to regulate the activity that is generating that cost, particularly when the financial drain is caused by a private, profit making venture. It can also be argued that the community is entitled to regulate activity that offends its sensibilities by being unduly violent or destructive. On this basis we prohibit base jumping and cage fighting; duels are illegal even if the participants are willing to engage in them, and boxing is strictly controlled with a view to minimising injury to the participants.

In their submissions to this inquest, the operator of BDV have belatedly acknowledged that aspects of the operation of the park are unreasonably dangerous. They have made some suggestions as to how these may be redressed. However I am of the view a holistic risk assessment is more appropriate than an *ad hoc*, piecemeal approach.

Having regard to these considerations and in view of the failure of the BDV operators to voluntarily take any remedial action, despite having ample evidence indicating that their facility is highly dangerous, I have no hesitation in concluding that some form of official regulation is required.

That poses the question of how this could best be achieved.

Professor Troutbeck recommends that Black Duck Valley should establish more positive relationships with motor sporting clubs and seek accreditation from national motor sport governing bodies. This would result in a full risk audit of the park's motorcycle and 4WD facilities being undertaken. Mr Granger of Motorcycling Queensland which is the state branch of Motorcycling Australia, says that such affiliation and accreditation would require a culture change at Black Duck Valley. His view in that regard is based on the lack of rules and regulations imposed by Black Duck Valley on members of the public using its facilities and its approach to risk management. Such change is highly desirable, in my view.

Motorcycling Queensland and 4WD Queensland are two organisations which produce guidelines, provide training and (in the case of Motorcycling Queensland) issue licences based on competence testing. Membership of those organisations is voluntary and the operators of BDV have expressly eschewed joining. However, I see no reason why facilities such as BDV could not be required to have membership of such organizations and comply with codes of conduct and other standards developed by such bodies. This would provide flexibility with the licensing authority being able to stipulate the appropriate organisational membership with reference to the activities carried on by the facility in question.

The State Government is in the process of developing guidelines called Adventure Activity Standards which are minimum safety, environmental and risk management standards that will apply, on a voluntary basis, to operators of outdoor recreation activities for dependant groups, i.e. those with a leader/client relationship. As I understand the position, no decisions have been made about how to ensure compliance with those standards.

Ms Dianne Farmer of the Department of Local Government, Sport and Recreation gave evidence that the standards would not apply to the usual activities at Black Duck Valley because the facilities are used by individuals rather than dependant groups. She said that it was too difficult to regulate individuals participating in such activities. This was despite the evidence that the standards impose conditions on operators rather than participants.

Further information provided by Ms Farmer sets out her department's position as follows –

> "*The matter is a complex policy issue. Some activities that people engage in are inherently dangerous and do not lend themselves to regulation when conducted on private property. As such, there is currently no single Queensland Government department with direct responsibility for regulating dangerous recreation activities on private land*."[13]

I am not persuaded that the policy difficulties can not be resolved. It may be that that the appropriate vehicle for regulation of activities conducted at Black Duck Valley and other similar facilities is the *Integrated Planning Act* 1997 (IPA). Ms Tracey Ryan of the Lockyer Valley Regional Council gave evidence of the park's history with the Gatton Shire Council so far as development applications are concerned. In the course of that evidence Ms Ryan outlined the process for assessing such an application.

She said that the conditions imposed on Black Duck Valley regarding health and safety were necessarily restricted by the IPA to matters of hygiene. Ms Ryan said that, although on one occasion a public safety condition had been agreed, the Council did not have power to make conditions regarding the safety of activities undertaken by members of the public at the park.

Her evidence was that for certain types of applications, other agencies have a role to play in assessing compliance with the relevant agency's criteria. Schedule 2 of the *Integrated Planning Regulation* 1998 lists appropriate agencies to have input to various development applications. For example, schedule 2 sets out that for an application involving a child care centre the referral agency is the chief executive under the *Child Care Act* 2002 and the referral jurisdiction is the performance criteria stated in the Queensland

[13] Letter from Dianne Farmer, Executive Director – Sport and Recreation, Department of Local Government, Sport and Recreation to the State Coroner, undated.

Development Code part 5.4. I see no reason why this mechanism could not be used to process development applications for outdoor recreation activities

## Recommendation 1 – Development applications from outdoor recreation facilities

*I recommend that the Integrated Planning Act and/or Integrated Planning Regulation be amended so that local authorities dealing with development applications concerning out door recreation facilities be required to refer the application for assessment by the Department of Local Government, Sport and Recreation.*

## Recommendation 2 - Mandating sport and recreation group membership

*I further recommend that the Department of Local Government, Sport and Recreation stipulate continuing membership of the appropriate outdoor sports or recreation body as a condition of the application's approval. Alternatively, the department could stipulate compliance with the relevant Adventure Activity Standard as a pre-condition to approval of the application*.

Unfortunately, unless the amendments were made retrospective, this mechanism would only have a prophylactic effect on future applications by DBV. Some mechanism is required to compel the operators to address the current ongoing calamitous situation at the park.

I suggest that could be provided by the Division of Workplace Health and Safety reviewing their earlier determination that public safety, rather than worker safety, was not a matter within their jurisdiction. It is clear that the division has given careful consideration to the scope of their authority in such matters. Tendered into evidence was a document entitled Enforcement note No.43 that acknowledges the ambit of the Workplace Health and Safety Act extents beyond incidents in which workers are injured and imposes obligations on those conducting businesses to ensure that other people are not affected by the conduct of the undertaking. It goes onto suggest a number of tests that should be applied to determine whether a particular incident is within the investigative jurisdiction of the division. I'm not sure that it would assist in determining whether incidents at BDV should henceforth be investigated by the division. I am firmly of the view that the division should undertake the investigation of such incidents. I consider they have statutory authority to do so and the staff with the necessary skills and experience. Their investigation should focus on whether there are breaches of the Act which warrant prosecution and whether changes are needed to the manner in which the undertaking is operated to reduce the likelihood of future incidents.

## Recommendation 3 – Investigation by WH&S

*I recommend that the Division of Workplace Health and safety review its determination that the injury to members of the public at worksites such as BDV are beyond its investigative jurisdiction. In the event that it is determined that the division does have authority to intervene, I recommend that as a matter of urgency they undertake a full risk audit of Black duck Valley and*

*take appropriate action in relation to the findings of such an audit as provided for in the Act.*

And finally, I will comment on a forensic matter. In some cases, a finding concerning consumption of alcohol by the deceased in the hours preceding death could be very significant. It is therefore desirable that the most accurate evidence bearing on the issue be collected at autopsy. Dr Drummer indicated that analysis of vitreous humour would assist to determine the issue.

## Recommendation 4 – Guidance to pathologists

*I recommend that the chief forensic pathologist develop a guideline to assist pathologists undertaking coronial autopsies identify those cases in which vitreous humour should be collected for toxicological analysis*

Michael Barnes
State Coroner
Brisbane
2 May 2008