TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

CORNACK, Coroner

COR-00003018/05(9)

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF JASON JOHN ZUPP

TOOWOOMBA

..DATE 12/10/2007

FINDINGS

CORONER: This is an inquest into the circumstances surrounding the death of Jason John Zupp.

At the commencement of my findings I acknowledge the presence today of Mr Zupp's fiancée, Lisa Marsh, who is here on her own behalf and on behalf of their son Noah, the parents of Mr Zupp, a sister of Mr Zupp and the grandmother of Mr Zupp who have been interested in the proceedings.

It is a long time since Mr Zupp died. Unfortunately now it is getting onto almost two years since his death, so it is disappointing that the inquest is held at such a late stage. There are a number of reasons for that and for that delay of course apologies should go to the family who obviously would have preferred to have an inquest at a much earlier time.

Under the Coroner's Act a Coroner who is investigating a death must find whether or not a death in fact has happened and must also find who the deceased person is, how they died, when they died, where they died and what caused them to die. The Coroner must give a written copy of the findings to the family members of the deceased person who have indicated that they will accept the document on behalf of the whole family and if an inquest is held any person who, as a person with a sufficient interest in the inquest, appeared at the inquest. That written copy of the findings unfortunately will not be available today. It will be prepared within the next week or so. I have determined to give my decision today orally so that there is a conclusion to the matter to avoid family

members having to travel from various parts to come back to hear the decision. If I wanted to give a decision in writing, there would be a delay and I believe that would just lead to unnecessary cost on behalf of all the parties.

The findings will simply encompass a form where in précis what is found in my decision now will be formulated so the family will hear a lot more words today than they will see in the form. I will supply a copy to Mr Jones on behalf of the family - he can disseminate that to the family members - and also a copy to the solicitors who instruct Mr Davies. If there is another family member who would like a copy, they need to give their particulars to the sergeant at the conclusion of the proceedings today and he will pass that information on to the Coroner's office at Dalby and, as best we can, we will be providing that information to the interested parties.

As part of the Coroner's duties, the Coroner must not include in the findings any statement that a person is or may be guilty of an offence or civilly liable for something. Therefore, this Court will not be making any findings about whether the Statewide company is civilly liable for anything or guilty of any offence nor will it be making any statements about Mr Zupp being guilty of any offence.

The Coroner may comment on anything connected with the death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent

deaths from happening in similar circumstances in the future. Obviously the evidence that has been heard here would indicate that there are comments that could be made to prevent deaths from happening in similar circumstances in the future and the sergeant who appears to assist the Coroner has indicated a number of matters.

At the commencement of the inquest we did hear a submission from someone in the truck-driving industry speaking on behalf of that industry indicating the pressure that was often put on long-distance truck drivers and about the lack of facilities provided to long-distance truck drivers to allow them to have proper breaks, indicating that there was no provision of clean, comfortable stopping places for them throughout Queensland. Of course, the trucking industry is of vital importance to Australia and to everyone in Australia and the bumper sticker that used to say "Without Trucks Australia Stops" is important and it is important that the community as a whole provides as best as possible a safe working environment for every long-distance truck driver in Australia.

The evidence that I have heard indicates to me quite clearly that Mr Zupp loved driving trucks and he loved his rig. It was an expensive rig and he was proud to be a truck driver and to drive his rig. It also indicates to me that he was a proud father of Noah and whilst he was having difficulties in his marriage I am not satisfied that the evidence proves that he was suicidal or that he was under intense pressure from his fiancée about any matter and I am not satisfied that he was

rushing back to Toowoomba fearing that he would not be able to see Noah the next day. In fact, I found it rather disappointing the way that material was raised by the employer as I believe it simply added to the emotional stress of the proceedings and it was unnecessary.

Many things are not in contention. It is clear that Mr Zupp, who was born on the 5th of May 1980, who was 25 years of age at the date of his death and a long-distance truck driver, died as a result of a motor vehicle incident where the large Mack truck he was driving overturned and the trailer spun around about 16 kilometres north of Taroom on the Leichhardt Highway. It is not exactly and precisely known when the incident occurred but passers-by found the truck overturned on its side at about 2330 hours on Saturday the 10th of December 2005.

I am satisfied that the truck and the trailers behind it had travelled down the left-hand table drain for about 100 metres where it had re-entered the road, crossing the road at an angle and rolling onto the left-hand side of the prime mover. The vehicle then proceeded down the right-hand table drain where it impacted with a bank and the three trailers slid around the road so that it faced the way it had been coming.

Mr Zupp was thrown out of the cabin and his body was found near the cabin. There is no evidence whatsoever that he had applied the brakes or in any way tried to prevent the crash.

The prime mover was a Mack truck registered 05-SGT Queensland. This happened on a very good section of bitumen. It would appear that Jason was not wearing his seatbelt as he was thrown from the vehicle. There is some evidence that he was in the practice of not wearing his seatbelt, but that would appear to be a red herring in this case because his failure to wear a seatbelt seems to have had no impact upon the collision or on his death.

Now, if Jason had completed his logbooks and kept them with him in the way he was required by law, then it would have been much easier for investigators to piece together his journey and to find out where he had been at any one time. It is clear that Jason had worked for the company for some time and it is clear that during that time practices were lax to say the least about logbooks. Jason had been issued with infringement notices for not completing his logbook twice in the past and when the logbook was seized there was no record of the journey he was undertaking at the time.

Some evidence from some of the drivers who gave evidence at this inquest indicate that that was a practice actively encouraged by the company, that logbooks were not completed as journeys were undertaken, that they were completed at the end of the week and they were fudged to make it look like the drivers had complied with all the legislation. It was clear that Jason had not completed his logbook for several days prior to the incident. In fact, it is reasonably clear on the evidence that he had driven in excess of 5,000 kilometres over

the six days prior to his death and he had not recorded those journeys in his logbook.

One of the most disappointing things about the investigation is that as soon as the police started their investigations they started to get information from witnesses who came forward to advise them about practices in the company that they thought were dangerous and that had in some ways led to the circumstances surrounding Jason's death. Now, that is an unusual thing. Witnesses do not normally come forward and give that information to investigators. In this case there were a number of witnesses who told police that the company regularly had their drivers drive vehicles that were over length, that they did not keep proper records, that they encouraged drivers to drive excessive hours, that they would pressure on drivers to drive excessive hours and all of these things, of course, have an impact upon the safety of the operation as a whole and on the safety of every individual driver driving under those conditions. The disappointing thing is that those matters should have been immediately, extensively, professionally and speedily investigated by the police or the Department of Transport. Because of some communication breakdown between the investigator, who was at Roma, and other authorities that were at Toowoomba, the company being at Toowoomba, those investigations were not carried out.

Now, there are some suspicions about what was happening at the company. There is an inference that is available that all was

not as it should have been at the company. Mr Eyers agrees that he did not chase up the drivers for their yellow slips. Some witnesses said he told them to wipe their "arse" with the slips. On the proceedings here, Mr Eyers has engaged solicitors and a barrister to come along for two days at this inquest and yet he produces not one record showing that the company had any appropriate procedures in place about the yellow slips or showing that there were any yellow slips from any other person. He produces a statement from one of the drivers saying that he always put in his yellow slips, but it would have been an easy thing for Mr Eyers to produce the company's records about the yellow slips. That seems to raise quite a lot of suspicion about what was happening at the company. Mr Eyers agrees that it was a reasonably regular occurrence that trucks left his depot when they were over length and that has safety implications for drivers as well.

This truck was over length and on this truck that Jason was driving the brakes had not been properly adjusted. In this case it was clear that Jason had been told two days before this happened that he needed glasses and he was not wearing glasses and he had not got the glasses and he was still driving a truck.

There is some evidence that some drivers watch DVDs as they are driving along. There was a DVD in the cabin with Jason. The evidence really seems to me on what I have seen and heard to establish that Jason was not watching a DVD and being distracted because if he had been distracted, as soon as the

vehicle left the road he would have taken some action either to brake or to bring the vehicle back onto the road in an appropriate way, so I am not satisfied that the evidence suggests he was watching a DVD.

This trip that Jason was on: he had started at Toowoomba and at the point of the crash he had driven 1,580 kilometres. That roughly equates to about just under 20 hours of driving in a 30 and a-half hour period at 80 kilometres per hour. Now, that does not include the time it took to load and unload and I accept on this journey there was a lot of time spent loading and unloading and there was quite a number of stops on the way. I am satisfied the evidence establishes that the trip Jason undertook could not have been lawfully done according to the fatigue management regulations that were in place at the time.

Jason was about 16 kilometres away from where he intended to pull over and go to sleep and have a rest. It was close to Christmas. He was looking forward to seeing his son the next day. There is no evidence that he had any family history of epilepsy and there is no evidence on the inquest that there was any vascular, metabolic, cardiac or cerebral event preceding the event that might explain a sudden loss of consciousness leading to him losing control of the vehicle. It is the medical opinion of one of the pathologists who has reviewed the documentation by Dr Guard that the most likely explanation is that Jason has gone to sleep.

Jason was not a new long-distance truck driver. He had been doing that for some time. It seems that truck driving was in the family as his father has experienced driving trucks as well. So no doubt Jason was aware of all of the risks involved with truck driving. He was intending to pull over and have a rest just down the road.

I find that the evidence satisfies me that what caused Jason to die was that he fell asleep whilst he was driving the truck and the truck left the road, crashed and this caused his death from injuries he suffered in that crash, his body being thrown from the vehicle.

According to the autopsy certificate the cause of death was hypovolemic shock and annexa due to massive trauma to the rib cage and rupture of the liver due to trauma with another significant condition being a fracture dislocation of the left femur and right knee. It is clear that there were a large number of injuries suffered by Jason as a result of being the driver in a motor vehicle collision and this is what caused his death.

On the evidence before me, there is a large amount of suspicion about what the company was doing and not doing to enforce the requirements of the law about fatigue management and proper safe driving practices for its drivers. Those have not been thoroughly investigated. It would appear from the evidence of a number of drivers that there was a culture where the company put pressure on drivers to keep driving and a

number of drivers have given evidence that they were forced to drive long hours without break. There are comments that can be made about those drivers and obviously they are drivers who are upset about certain things to do with the company and upset about losing a friend and colleague when Jason died. Of course, it would have been a much more preferable set of circumstances if those suspicions and issues had been properly investigated so that I would be able to make proper findings about them but in the circumstances I am unable to do that because no thorough investigation was completed.

Certainly comments can be made on the evidence about ways to prevent deaths from happening in similar circumstances in the future and that is that there should be greater enforcement or compliance with all fatigue management practices to ensure that those doing long-distance truck driving have adequate rest breaks and that companies employing people for long-distance truck driving create a culture of compliance rather than a culture of subversion of the laws about that.

As a side issue, of course, if the community could provide greater resources for properly resourced clean and comfortable rest stops for truck drivers at regular intervals on all the highways, that would of course lead to a greater system where truck drivers can pull over more readily and take the required breaks.

I do not think I need to make any further findings.

I also pass on my condolences to the family members who have been here.

I now close the inquest.
