OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Joel Timothy Birse**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Charleville
FILE NO(s):	2007/123
DELIVERED ON:	24 March 2010
DELIVERED AT:	Blackall
HEARING DATE(s):	23 & 24 March 2010
FINDINGS OF:	Colin Strofield, Coroner
CATCHWORDS:	CORONERS: Inquest – Death of a child, Blackall Show, motor cycle accident

REPRESENTATION:

Counsel Assisting	Sergeant LM Smith
Barcoo Pastoral Society Inc.	P. Van Grinsven, i/b Barry and Nilsson Lawyers
Kylie Richards mother of the deceased	JD Carpenter, i/b Skewes and Dempster Solicitors

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. These are my findings in relation to the death of Joel Timothy Birse. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

The Blackall Show was held over the weekend of the 5 and 6 May 2007. Part of the activities being conducted at the show involved a junior motorcycle event. It seems that this activity, once reserved for and associated with horses, was a motorcycle gymkhana. One might opine that the motorcycle has now almost completely replaced the horse in many rural locations.

Joel had travelled with Mr Bird, his aunt's then partner, to collect a Yamaha RK50 mini-bike from an address here in Blackall. From there they travelled to the Blackall showgrounds.

After attending to the registration requirements and processes with Mr Bird, Joel kick-started the motorcycle and went for a warm up ride. As Mr Bird needed to travel the short distance back to his residence to collect some water he told Joel not to ride the motorbike and to leave it parked until the event started.

In the short time that Mr Bird was away from the showgrounds a dreadful and tragic accident occurred. Joel's motorcycle collided with a motorcycle ridden by another young boy, Hugh Hayne. Hugh was almost three months short of his 10th birthday.

Despite their apparent tender years both boys, it seems, were not inexperienced motorcycle riders.

Hugh had arrived at the showgrounds with his parents about 15 minutes prior to the scheduled starting time of the junior motorcycle events. After also attending to the registration requirements and processes with his mother, Hugh started his motorcycle and went for a warm up ride. Perhaps some 10 or so minutes later the dreadful and tragic accident occurred.

An ambulance was summonsed. Exhibits 1 and 9 indicate the call was made to the Queensland Ambulance Service at the 9.12am on the 6 May. At 9.14am an ambulance was dispatched, arriving at the accident scene some six minutes later at 9.20am. The ambulance records revealed the ambulance arrived at the Blackall Hospital at 9.30am.

Prior to the arrival of the ambulance at the showgrounds the officer-in-charge of the Queensland Ambulance Service here in Blackall and a registered nurse provided professional assistance to Joel. Both of these people happened to be at the showgrounds but they were not there in any official capacity.

Joel had suffered a fatal penetrating wound to his right temporal bone. No

other injury or bruising was noted at autopsy.

Both boys were wearing helmets at the time of the accident. The wearing of long pants, appropriate shirt and footwear and, not surprisingly, a helmet was a mandatory requirement for participation in the motorcycle events.

It is perhaps speculation that the helmet worn by Joel was ill-fitted or a helmet belonging to an older person. Hugh, slightly older than Joel, was wearing a helmet the same size as Joel's.

It remains uncertain how the penetration to Joel's right temporal bone occurred.

The temporal bone where the puncture occurred was between one and two millimetres in thickness and the fracture of the bone measured 40 millimetres vertically and 30 millimetres horizontally.

Although the helmet was not retained and was appropriately destroyed by the Queensland Police Service, the helmet worn by Joel was a medium 57 to 58 centimetre size full-face O'Neal 694 brand helmet. The photographs taken by police of the helmet do not disclose any penetrating damage to the helmet itself.

Mr Bird's short absence from the showgrounds, that is when he returned to his residence to obtain the water, meant parental or guardian supervision was also absent during that time and it was during that time that this dreadful and tragic accident occurred.

The weight of the evidence causes me to conclude that neither boy, or for that matter any competitor, was at any time prior to this dreadful and tragic accident riding in anything other than an orderly and appropriate fashion.

The loss of Joel was, as I have said, the result of a dreadful and tragic accident. Although some witnesses touched on what steps might have prevented the accident occurring, such suggestions were made with the benefit of hindsight.

As I am required pursuant to the provision of the *Coroners Act 2003* I make these formal findings:

Identity of the deceased - The deceased person was Joel Timothy Birse.

How he died - On the morning of Joel was riding a Yamaha RK50 mini-bike when a collision occurred with a Honda CRT 80F mini-bike at the Blackall Show. Both riders were wearing helmets. Joel died on the 6th of May 2007 here in Blackall.

Place of death - Blackall Showgrounds, Salvia Street, Blackall 4472.

Date of death - 6 May 2007.

Cause of death - The cause of death was a penetrating death wound to his head due to or as a consequence of motorcycle trauma.

I thank the officer assisting me, the legal representatives and Mr Birse, who appeared without legal representation, for their conduct at this inquest.

Finally, to the parents of Joel may I extend my sincere sympathy. To experience the loss of a child at such a young and tender age surely is something beyond what I can imagine.

I close this inquest.

Colin Strofield
Coroner
Blackall
24 March 2010