CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Meaghan Baird and Cameron Bloomfield Inquiry into fire which accompanied the deaths.
Hearing date:	6 June 2019
Date of findings:	6 June 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – deaths of two people in single heavy vehicle crash - vehicle burst into flames - which of the deceased was the driver – to what extent did drugs and/or driver fatigue cause the crash – whether change is needed to regulation of long haul trucking operations which use heavy vehicles – cause and origin of fire which accompanied the fatal crash.
File number:	2014/110763 2014/110786
Representation:	Counsel Assisting the inquest: M Cahill of Counsel i/b Crown Solicitor's Office Vellex Pty Ltd, Raymond Vella and Dylan Vella: P Lowson of Counsel i/b Holman Webb Solicitors.

Findings:	**<u>Inquest into the death of Meaghan Baird</u>** **Identity** The person who died is Meaghan Baird. **Date and place of death**: Meaghan Baird died on 10 April 2014 at Herons Creek, NSW 2443. **Cause of death:** The cause of Meaghan Baird's death is severe head injuries which she received when the heavy combination vehicle in which she was a passenger left the road, rolled over and caught on fire. **Manner of death:** Meagan Baird's fatal head injuries were sustained when the heavy combination vehicle in which she was a passenger left the road and rolled over, most likely as a result of impaired driving caused by the acute effects of methylamphetamine. **<u>Inquest into the death of Cameron Bloomfield</u>** **Identity** The person who died is Cameron Bloomfield. **Date and place of death** Cameron Bloomfield died on 10 April 2014 at Herons Creek, NSW 2443. **Cause of death** The cause of Cameron Bloomfield's death is the effects of fire due to the inhalation of smoke. **Manner of death** Cameron Bloomfield's death occurred when the heavy combination vehicle which he was driving left the road and rolled over, most likely as a result of impaired driving caused by the acute effects of methylamphetamine. **<u>Inquiry into fire</u>** The fire which accompanied the fatal crash took place on 10 April 2014 at Herons Creek, NSW 2443. It commenced after the heavy combination vehicle rolled over, and its cause was related to that roll over. It is not possible to determine the fire's specific cause, or point of origin within the vehicle.

Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the deaths of Meaghan Baird and Cameron Bloomfield. These are also the findings of an inquiry held simultaneously with the inquest, into the cause and origin of a fire which took place at the time of the two deaths.

Introduction

1. On 10 April 2014 Meaghan Baird aged 27 years and Cameron Bloomfield aged 29 years died in a single vehicle crash on the Pacific Highway near Kew, on the mid-north NSW coast. Ms Baird and Mr Bloomfield were travelling in a prime mover with two fully laden combination trailers. There was evidence that Mr Bloomfield, who was the likely driver, and Ms Baird had ingested a significant amount of methylamphetamine within hours of the crash. There was also some evidence that Mr Bloomfield was fatigued. The inquest examined what role these two features may have played in the fatal accident, and whether there is a need for changes to the regulation of long haul trucking operations which use heavy vehicles.

The role of the Coroner

2. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. A Coroner conducting an inquiry concerning a fire must also make findings as to the date and place of the fire and where possible, its cause and origin.

3. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The lives of Mr Bloomfield and Ms Baird

4. Cameron Bloomfield was born on 8 September 1984 in Queensland. Together with his sister he was brought up in Rockhampton by his mother Margaret and step father Gary. As a boy he loved working with mechanical things and he later obtained his licence for driving heavy vehicles in different combinations. He commenced work with a business owned and operated by Mark Aitchison, driving heavy vehicles between Brisbane and Sydney and doing local deliveries.

5. Mr Allen Mark Aitchison was the sole proprietor of Archerfield Transport and Storage, which he operated from a freight depot in Brisbane. In the conduct of his business he owned and directed the use of heavy combination vehicles. He also scheduled the operations of these vehicles and employed drivers for

them. The business was regularly sub-contracted to transport freight between the Brisbane depot and a depot in Moorebank, NSW. The distance between the two locations is about 936 kilometres. It was on one of these journeys that Mr Bloomfield and Ms Baird lost their lives.

6. At the time Mr Bloomfield died he had two young children with his then partner Krystal Thomas, and two children from an earlier relationship. He had also entered a relationship with Meaghan Baird whom he knew from their Rockhampton schooldays. Around the time of their deaths Ms Baird sometimes accompanied Mr Bloomfield on his long haul trips.

7. Meaghan Baird was born on 31 October 1986. She grew up with her brother David and their parents Trish and Richard in Yeppoon, Queensland, where the family enjoyed camping and fishing trips. Meaghan supported herself working in cafes. She and Mr Bloomfield had remained in contact after their schooldays, and in 2012 they recommenced their relationship. A friend reported that both were regular users of crystal methamphetamine which they smoked.

8. About a week prior to the fatal crash Ms Baird's parents visited her at her home in Ipswich. Ms Baird spoke to her mother of her fears that Mr Bloomfield was so exhausted from his driving work that he might fall asleep at the wheel. In addition Ms Baird's mother described a dinner with Mr Bloomfield that week where he reported being exhausted from his work. Ms Baird told her parents she had obtained her heavy vehicle licence so she could help Mr Bloomfield on trips when he got tired. Friends reported that on long haul journeys she made with Mr Bloomfield she was known from time to time to drive the vehicle.

9. Meaghan Baird's mother, father and brother have been devastated by her death. For the sake of their mental wellbeing they chose not to attend the inquest, instead providing a written document expressing their grief and love for Meghan and sharing their memories of her. They described an active and loving young woman who had much to live for, and whose death has left a big hole in their lives.

10. For reasons which are entirely understandable, Mr Bloomfield's parents also did not attend the inquest. Mr Bloomfield's cousin Mr Andrew Leondiou attended. It was evident from the statements which Mr Bloomfield's parents and de facto partner provided to police that they loved him very much and miss him deeply.

The events of 8 and 9 April 2014

11. On the night of 8 April 2014 Mr Bloomfield, accompanied by Ms Baird, commenced a long haul return journey from the Brisbane depot to Sydney. They arrived in Sydney early on the morning of 9 April. During that day Mr Bloomfield was contacted several times by Mr Aitchison during what was supposed to be his 7 hour continuous rest break.

12. That evening Mr Bloomfield, again accompanied by Ms Baird, commenced the return trip to Brisbane, departing the Sydney depot at about 8.30pm. Mr Bloomfield was driving a 2005 model prime mover which towed two fully laden combination trailers containing corrosives, paint thinners and other flammable and hazardous materials.

13. The crash happened very soon after 3.00am, at a location on the Pacific Highway just north of Kew on the NSW mid-north coast. A witness driving northwards reported seeing Mr Bloomfield's vehicle overtaking his car. When the witness approached the crest of a hill he lost sight of the vehicle, then saw it ahead travelling off the left side of the road, falling to its side and sliding. The cabin was fully on fire which quickly spread to the trailers, making it impossible to approach. He and another driver immediately contacted emergency services.

14. When police arrived at the scene the cabin and trailers were engulfed in flames. The heat was intense and aerosol cans from the load were exploding into the air. It took NSW Fire and Rescue officers until 5.30am to extinguish the fire. Soon afterwards the bodies of Mr Bloomfield and Ms Baird were recovered.

15. Forensic examiners from NSW Police's Crash Investigation Unit concluded from tyre markings that the prime mover and its trailers had left the western gravel edge of the Highway and travelled 100 metres in a north westerly direction before coming to rest. They concluded the entire vehicle had fallen onto the driver's side and had caught on fire, incinerating its occupants and most of the vehicle itself

16. The investigators were unable to determine why the vehicle had left the road. There was no evidence of braking or sharp turning on the road surface to suggest it was out of control. Nor could they find any evidence that another vehicle was involved.

17. Due to the extensive fire damage it was impossible to determine the vehicle's pre-impact condition, although there was no reliable evidence that any mechanical defect within the prime mover or trailers had caused or contributed to the crash. Nor were the forensic examiners able to determine which of the two persons had been driving at the time of the crash.

The autopsy and toxicology reports

18. An autopsy examination of Ms Baird was performed by forensic pathologist Dr Jane Vuletic. She found the cause of Ms Baird's death to be head injuries, with a significant contributing condition of methylamphetamine toxicity. From an examination of Ms Baird's airway Dr Vuletic was able to conclude that she had died before the cabin ignited, as a result of her severe head injuries.

19. Dr Vuletic also performed an autopsy examination of Mr Bloomfield. She concluded he had died as a result of the effects of fire, most probably due to the inhalation of smoke.

20. Analysis of the post mortem blood samples of Ms Baird and Mr Bloomfield showed the presence of methylamphetamine at levels assessed to be in the toxic to lethal range. Specialist physician and clinical toxicologist Professor Alison Jones provided an expert opinion that the couple had most probably ingested the methylamphetamine within a few hours of their deaths. In her opinion, the recorded levels of methylamphetamine could have contributed to the crash by impairing the driver's driving ability, or causing the driver's death by coma, respiratory depression or fatal cardiac arrhythmia.

21. The above evidence establishes the time, place and cause of these two tragic deaths. The issues examined at the joint inquest related to the manner of their deaths, which I now address. No witnesses were called to give oral evidence, with the coronial brief of evidence providing the totality of the evidence.

Which of the two deceased persons was driving the vehicle at the time of the crash?

22. The crime scene examiner Detective Sergeant Guymer, and the investigating officer Detective Senior Constable Jason Bentley were unable to determine whether it had been Mr Bloomfield or Ms Blair who was driving the vehicle at the time of the crash.

23. Subsequently a report was obtained from Mr Michael Griffiths and included in the brief of evidence. Mr Griffiths is a bio-medical and mechanical engineer specialising in vehicle safety research and crash investigation. From his review of the evidence he concluded it was likely Mr Bloomfield had been driving at the time of the crash. He based this conclusion on the location of Ms Baird's body within the cabin. As a result of the vehicle's roll over to the driver's side Ms Baird had been partially ejected from the cabin towards the driver's side window. This indicated her body had been subject to high energy forces to the right, suggesting she had been positioned in the left front passenger seat.

24. I accept the submission of Counsel Assisting, that there is sufficient evidence to find that Mr Bloomfield was driving the vehicle at the time of the crash.

The role which the ingestion of methamphetamine played in the crash

25. I have noted the conclusions reached by Professor Jones, concerning the amounts of methamphetamine in the couple's blood samples and the likely impairment this would have caused to their ability to drive. I have noted her further conclusion that the amounts ingested by Mr Bloomfield were capable of inducing coma with respiratory depression, or a fatal cardiac arrhythmia.

26. I accept the submission of Counsel Assisting, that the evidence supports the conclusion that the presence of a toxic to fatal level of methylamphetamine in Mr Bloomfield's blood provides an explanation for his apparent loss of control of the vehicle that night.

The role that driver fatigue may have played in the crash

27. There was evidence which suggested Mr Bloomfield was fatigued in the days and hours leading up to the night of 9 April. Some of this evidence is described in paragraph 8 above. The brief also contained statements from people who were in contact with Mr Bloomfield on 9 April, who either observed him looking tired or heard him complaining he had not been able to get enough sleep.

28. It is also the case that following the crash, Mr Aitchison and others associated with the freight depots in Brisbane and Sydney were charged with what are known as fatigue regulation related offences. The prosecutions were undertaken pursuant to the *Heavy Vehicle National Law (NSW),* and are further described below.

29. It is important to note however that in none of the prosecutions was it alleged that fatigue was the cause of the fatal crash. The reason for this is that it is not possible to determine how many hours Mr Bloomfield had in fact driven the vehicle on the nights of 8 and 9 April, because of the known possibility that Ms Baird had driven it for some periods. There was evidence before the court that from time to time Mr Bloomfield allowed her to drive the heavy vehicles which he used; and further that the reason she sometimes accompanied him on his long haul trips, including this one, was to keep him company and assist him with his fatigue.

30. In these circumstances it is not possible to exclude the possibility that Ms Baird drove the vehicle for some periods during the nights of 8 and 9 April. Consequently it is not possible to be certain about the number of hours Mr Bloomfield himself was driving during this period.

31. It is for this reason that I am unable to make a positive finding that driver fatigue on Mr Bloomfield's part caused the fatal crash.

The prosecutions

32. In 2016 the NSW Roads and Maritime Service commenced road transport '*chain of responsibility*' prosecutions of a number of people and corporations, arising out of this tragedy. The prosecutions were undertaken pursuant to the *Heavy Vehicle National Law (NSW)* [the HVNL], which is further described below. Although the charges are known as 'fatigue regulation related offences', none alleged that Mr Bloomfield's capacity to drive that night was in fact impaired by fatigue.

33. Mark Aitchison was charged with failing to take all reasonable steps to ensure that his business practices did not cause Mr Bloomfield to drive while in breach of his work rest hours requirements. It was found that he did not have a system to check the work diaries of his drivers, that he failed to develop and implement a fatigue management training program for his drivers, and failed

to have a practice that included use and monitoring of in-vehicle GPS systems.

34. Arising out of their '*chain of responsibility'* obligations, other parties were also charged with offences under the HVNL due to their involvement in scheduling Mr Bloomfield's trips and loading his vehicle. Those responsible for scheduling were charged with having failed to develop trip plans which allowed drivers to complete trips other than within strict time limits. Those involved in loading Mr Bloomfield's vehicle were charged with having failed to take reasonable steps to ensure that he did not drive while he was apparently fatigued.

35. All parties received convictions and fines for their offences.

The amended Heavy Vehicle National Law [HVNL]

36. As a result of this tragic accident, is there a need for change to the regulation of heavy vehicle operations, so as to reduce the risk of similar incidents occurring in the future?

37. Deaths resulting from heavy vehicle accidents have been a cause for public concern for many years. The issue is of significant concern for Roads and Maritime Services officers, who conducted extensive investigations into this incident and another taking place in 2012. RMS investigators pointed to recurring features in heavy vehicle crashes, of fatigued drivers and the failure of heavy vehicle operators to have systems in place to ensure drivers did not drive while in this condition.

38. At the time of this fatal crash there did not exist a nationally consistent approach to enforcing general safety duties in the context of long haul trucking operations. Since then however, the HVNL has been amended to create a single regulatory scheme for regulating heavy vehicle operations. The amendments introduce an industry specific 'general transport safety duty' with accompanying risk-based offences. In this regard they mirror the model adopted within harmonised work place health and safety legislation.

39. The amended legislation imposes '*chain of responsibility'* safety obligations on heavy vehicle drivers, operators and off-road parties including consignors and consigness, schedulers and loaders. Breach of the obligations gives rise to risk-based offences which carry enhanced penalties. The legislation is enforceable by the National Heavy Vehicle Regulator and by state enforcement authorities including the RMS.

40. The amended HVNL came into operation on 10 February 2014. All Australian states and territories with the exception of Western Australia and the Northern Territory are participating jurisdictions.

41. Although the new safety duties and offences are still in their early days of operation there is no basis to question their sufficiency, in the context of

considering what legislative changes might be required to reduce the risk of similar incidents occurring in the future.

42. For this reason, at this stage I do not consider there is scope to consider whether any further changes are needed to the regulation of heavy vehicle operations.

The fire which accompanied the crash.

43. The evidence received at the inquest enables limited findings to be made regarding the fire which incinerated the cabin and trailers that night. I am able to find that the fire commenced after the vehicle had rolled over. This may be deduced from the expert evidence of forensic pathologist Dr Vuletic that Ms Baird had died from her head injuries, sustained as a result of the roll over, before the fire engulfed the cabin.

44. It is highly likely that the fire commenced for reasons related to the crash; however the evidence does not enable a more specific finding to be made as to its cause, or its point or origin within the vehicle.

Conclusion

45. The crash which took the lives of these two people was shocking in its circumstances. And it has left parents, brothers and sisters, and children grieving the loss of their beloved family member. On behalf of all of us at the Coroner's Court I hope these families will accept our sincere sympathy for their loss.

46. The assistance provided to me by Counsel Assisting Mr Mark Cahill and those instructing him within the Crown Solicitor's Office was outstanding, and I thank them for this. I also acknowledge the fine investigative work undertaken in this matter by RMS investigators Nigel Smith and David King, and the Officer in Charge DSC Jason Bentley.

47. I close this inquest.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the deaths occurred and make the following findings in relation to them.

Identity
The person who died is Meaghan Baird.

Date and place of death:
Meaghan Baird died on 10 April 2014 at Herons Creek, NSW 2443.

Cause of death:

The cause of Meaghan Baird's death is severe head injuries which she received when the heavy combination vehicle in which she was a passenger left the road, rolled over and caught on fire.

Manner of death:
Meagan Baird's fatal head injuries were sustained when the heavy combination vehicle in which she was a passenger left the road and rolled over, most likely as a result of impaired driving caused by the acute effects of methylamphetamine.

Inquest into the death of Cameron Bloomfield

Identity
The person who died is Cameron Bloomfield.

Date and place of death
Cameron Bloomfield died on 10 April 2014 at Herons Creek, NSW 2443.

Cause of death
The cause of Cameron Bloomfield's death is the effects of fire due to the inhalation of smoke.

Manner of death
Cameron Bloomfield's death occurred when the heavy combination vehicle which he was driving left the road and rolled over, most likely as a result of impaired driving caused by the acute effects of methylamphetamine.

Inquiry into fire

The fire which accompanied the fatal crash took place on 10 April 2014 at Herons Creek, NSW 2443. It commenced after the heavy combination vehicle rolled over, and its cause was related to that roll over. It is not possible to determine the fire's specific cause or point of origin within the vehicle.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

7 June 2019