



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION: **Non-inquest findings into the death of Corey James Beitzel, Baylee Maree Jenkins, Shaun Michael Ranger and Chandler Kody Ranger**

TITLE OF COURT: Coroners Court

JURISDICTION: Mackay

DATE: 2 April 2026

FILE NUMBERS: 2025/3420
2025/3424
2025/3425
2025/3428

FINDINGS OF: Wayne Pennell
Mining and Resources Coroner and Northern Coroner

CATCHWORDS: CORONERS: traffic accident – excessive speed – driver lost control – evidence of speeding prior to collision – dangerous overtaking of vehicles – crossing double lines – weather, road surface, environmental factors and vehicle roadworthiness are not contributory factors – excessive speed, driving behaviour and loss of control of the vehicle are the primary contributing factors to the accident – six year old child not properly restrained within the vehicle

Background

1. At approximately 10:52am on a clear, sunny morning on 20 July 2025, a fatal head on traffic accident occurred on the Capricorn Highway, approximately 10 kilometres east of Comet. The crash involved a Holden Commodore sedan travelling east and a Toyota Hilux utility travelling in the opposite direction towards Comet.
2. The driver of the Holden Commodore was Shaun Michael Ranger (Mr Ranger) who was born on 10 September 1996, aged 28. Seated in the front passenger seat was Corey James Beitzel (Mr Beitzel), born on 16 January 1993, aged 32. In the rear seat were Baylee Maree Jenkins (Baylee) who was born on 2 May 2018, aged 7 and Chandler Kody Ranger (Chandler), born 24 April 2019. He was aged 6.
3. The accident resulted in the death of all four occupants in the Holden Commodore. The two occupants of the Toyota Hilux were seriously injured and were airlifted to hospital.
4. Subsequently, on 21 July 2025, the deaths of Mr Ranger, Mr Beitzel, Baylee and Chandler were reported to the coroner because each of their deaths met the definition of a reportable death pursuant to the provisions of the *Coroners Act 2003* ('the Act').
5. The Act provides that the role of a coroner in a coronial investigation is to investigate reportable deaths to establish, if possible, the cause of death and how the person died.
6. The purpose of a coronial investigation is to establish facts, and not to cast blame or determine criminal or civil liability. An investigation can also, where appropriate, examine systemic failures that may have contributed to a death and make recommendations for improvement.

Police (FCU) investigation

7. At the conclusion of the police investigation, I was provided with a comprehensive report from the Queensland Police Service Forensic Crash Unit (FCU). The investigating FCU officer provided a number of opinions as to the circumstances and cause of the accident. I accept many of those opinions and where appropriate, I have adopted them into these Findings.
8. Mr Ranger held a current Queensland Open C class drivers licence. He had an extensive traffic history consisting of eight offences of exceeding the speed limit, five SPER suspensions, and had previously been convicted of unlicensed driving. His criminal history consisted of the offences for production of dangerous drugs, possess drug utensils and trespass. A Toxicology analysis of a sample of his blood taken at autopsy did not reveal the presence of alcohol, although tetrahydrocannabinol (THC) was detected at an approximate level of 0.04 mg/L. That suggests that he had consumed a cannabinoid substance (cannabis) at an indeterminable time prior to death.

9. The Toyota Hilux utility was driven by Curtis Wilson (Mr Wilson) and the passenger was Jonathan Green (Mr Green). Mr Wilson held a current NSW Open HC class drivers licence. He had no recorded traffic history or criminal history. Mr Wilson's vehicle was fitted with GPS data tracking, including derived vehicle speeds that are calculated every five seconds. The data showed that the vehicle departed Blackwater at 10:30am, travelling at a maximum speed of 98 kilometres per hour towards Comet. At 10:48am, being a few minutes before the collision, the vehicle was travelling at 88 kilometres per hour. I find that the speed of this vehicle was not a contributing factor to the cause of the accident and nor is there any evidence of driver inattention by Mr Wilson.
10. The Capricorn Highway at the collision location is oriented in an east-west direction. The road consists of a single lane in each direction, separated by a double centre line. Outer fog lines are painted on the outside edges of the sealed surface, and there are worn auditable tactile strips, guideposts and reflectors (cat eyes) along the edges.
11. The posted speed limit for this section of the highway is 100 kilometres per hour. The road is constructed of chipseal and was dry at the time of the collision. For east bound vehicles, the roadway is a sweeping open left-hand bend with reduced visibility because of an embankment and vegetation lining the roadway. The FCU investigator identified no defects in the road surface, markings, or surrounding infrastructure.
12. On the information obtained by the FCU investigation, the weather conditions at the time of the accident were clear and sunny, with no visibility issues or environmental factors contributing to the accident. Nor is there any evidence of any livestock or other native animals present at that time or involved in the accident. I therefore find there were no weather, environmental factors or animals which contributed to this accident.
13. The FCU investigation determined that as the Holden Commodore travelled eastbound along the Capricorn Highway towards Blackwater. Just prior to the collision, the calculated minimum speed of this vehicle was between 151 to 165 kilometres per hour. This was based on the yaw calculations. As this vehicle navigated the sweeping left hand bend, it partially left the left-hand road shoulder, striking a guidepost, after which Mr Ranger applied a heavy right-hand steering input, causing the vehicle to rotate in a clockwise yaw.
14. The Holden Commodore then crossed into the opposing lane and collided with the westbound Toyota Hilux utility driven by Mr Wilson. The Holden Commodore sustained catastrophic damage, splitting that vehicle into two sections. The rear section was located to the northern road shoulder with the body of Baylee, who was still fastened within the right seatbelt. The front section of the Holden Commodore was located incinerated on the southern road verge containing the charred remains of Mr Ranger, Mr Beitzel and Chandler.
15. The Toyota Hilux utility driven by Mr Wilson was found overturned on its roof on the southern road verge. It too was incinerated, however both Mr Wilson and Mr Green had

been extracted from that vehicle by members of the public. There were both subsequently treated on scene by the QAS before being airlifted to hospital.

16. The impact area where the vehicles collided was identified to have occurred within the west bound lane. A series of gouge marks identified the contact point. The assessment of the FCU investigation was that the impact point places the Holden Commodore on the incorrect side of the roadway, and the Toyota Hilux within its designated lane.
17. No pre-impact brake lockup marks associated with the Toyota Hilux were identified, suggesting that either Mr Wilson had insufficient time to react, or that his vehicle's ABS system prevented marks from being left, or that there was insufficient brake force applied. I am satisfied that given the analysis of the speed of the vehicle driven by Mr Ranger, there is every likelihood that Mr Wilson did not have time to react.
18. A mechanical inspection was undertaken on the Holden Commodore. Because of the extent of fire damage, impact damage, and missing components, an accurate opinion regarding the overall mechanical condition of the vehicle could not be formed. Notwithstanding that, the inspection showed that the rear brakes were undamaged and appeared to be in satisfactory condition. The front right brake pads and left inner brake pads were found to have satisfactory friction material thickness.
19. The extent of fire damage, impact damage, and missing components prevented any inspection of the vehicle's electrical systems.
20. In respect to the vehicle's tyres, the front tyres were incinerated and could not be inspected, however both rear tyres were found to be in satisfactory condition.
21. The FCU investigation established that on 17 July 2025, Mr Ranger re-registered the Holden Commodore. That process required a Vehicle Safety Certificate, which was issued on 16 July 2025.
22. I accept that the vehicle was of a roadworthy condition at the time of it being registered, and I find there is every likelihood that three days later when the accident occurred it was still in a roadworthy condition.
23. Because the FCU investigation revealed that the Toyota Hilux was not a contributory factor to the accident, it was determined that a mechanical examination was not warranted. I accept and adopt that view taken.

Witnesses

24. A number of witness statements and versions were obtained. Although none of the witnesses actually saw the collision between the vehicles, there were many that arrived upon the scene within minutes or even sooner. Those witnesses were also able to provide significant information about the manner in which the Holden Commodore was being driven along the Capricornia Highway.

25. In regard to the occupants of the Toyota Hilux, Mr Wilson recalls that he and Mr Green were driving towards Emerald. As he drove along the Capricornia Highway, he engaged the cruise control of the Toyota Hilux, setting the limit of speed at 100 kilometres per hour. He recalls listening to music and talking to Mr Green. His last recollection was a flash of a car swerving in front of him and seeing a child in the middle of the back seat of that car.
26. After the accident, his first memory is looking at the sky and being told that he had been in a crash and not to move because of possible neck injuries. He recalled being moved further down the road and hearing noises which he described as a pop and a bang. He also recalled seeing Mr Green covered in blood.
27. Mr Green had no memory of the accident or the events leading up to it, and nor did he have any memory of the previous two to three days. Following the crash, he experienced memory loss for approximately one and a half to two weeks, although this gradually returned. Despite that, he still cannot recall the specific events of the crash or the activities leading up to it.
28. Mr Ranger's partner, Renae Jenkins (Ms Jenkins) was interviewed as part of the FCU investigation. She is the mother of the deceased children, Chandler and Baylee. She and Mr Ranger had been in a relationship for nine years and they planned to marry on their tenth anniversary. Mr Ranger was described as a committed family man and the biological father of Chandler, but not the biological father of Baylee.
29. Ms Jenkins said that the family was returning home to Blackwater after a camping trip at Riley's Crossing, which is located in the Comet area. They had arrived in that area the previous Friday, 18 July 2025 and left on the morning of the accident. Mr Ranger was excited to drive his Holden Commodore after just having regained its registration following an engine swap.
30. When travelling home, they were in two vehicles. In the car with Ms Jenkins was Tanika Thompson, Reagan Low and Saphora Ranger. Their intention was to all arrive home in Blackwater with plans to go horse riding later in the day.
31. She said that they had both consumed alcohol during the trip, however alcohol was not detected in Mr Ranger's toxicology result. This suggests that alcohol was not a contributing factor to the accident. She revealed that he had consumed cannabis the night before, which could account for the presence of THC in his blood. She added that Mr Ranger struggled with bipolar, and anxiety and was on medication for bipolar disorder, however the toxicology results did not show the presence of any medication.
32. Ms Jenkins also said that during the previous night, she and Mr Ranger had limited sleep because their daughter had been unwell. I have carefully considered whether fatigue may have played a part in the accident and taken into account the relatively short distance between Riley's Crossing where the family camped and the collision location.

33. The distance from Riley's Crossing to Comet is approximately 27 kilometres, with Google maps suggesting that it would take 27 minutes to travel between those two locations.
34. Having regard to Mr Ranger's propensity to travel at speed on the highway, I have no difficulty in accepting that the time he took to travel back to Comet from Riley's Crossing would have been in much quicker time than what Google maps allowed.
35. Witnesses place Mr Ranger's Holden Commodore parked in Comet, therefore indicating that he had stopped there for an indeterminable time. The collision scene is 10 kilometres from Comet, therefore adding approximately another four to five minutes of travel time having regard to the speed Mr Ranger travelled at.
36. When careful consideration is applied to those features just identified, Mr Ranger's overall travel time between Riley's Crossing and the collision scene is approximately 30 minutes, excluding the indeterminable amount of time he was stopped in Comet.
37. On the evidence currently before me, including the witness versions outlined below, I am not satisfied that driver fatigue played any role in this accident.
38. Steven and Diane Mulford owned a motorhome and were part of a group of motorists who had travelled for a trip out to Longreach. On the morning of the accident, they departed Emerald and were heading along the Capricornia Highway towards Rockhampton with Mr Mulford driving. The cruise control on their vehicle was set on 100 kilometres per hour.
39. They saw a white Holden Commodore overtaking vehicles at high speed, which they estimated to be between 140 and 150 kilometres per hour. This vehicle also overtook them, and as the vehicle moved back into the east bound lane it abruptly undertook a rapid manoeuvre and cut in front of their vehicle with a noticeable "speed wobble".
40. They then saw the Holden Commodore overtake two four-wheel drives ahead of them, still travelling at high speed and crossing over double lines on a bend as it did so. Mr Mulford noticed brake lights activated on one of the four-wheel drives as they approached the bend, prompting him to slow his vehicle down. Moments later, they lost sight of the Commodore and the four-wheel drives as those vehicles went around the bend.
41. When Mr and Mrs Mulford drove around the same bend shortly afterwards, they encountered the aftermath of the crash in what they described as carnage. The Holden Commodore had split into two, with the rear section on the opposite side of the highway.
42. Derek Butcher was driving his Toyota Land Cruiser along the Capricornia Highway with the vehicle's cruise control set on approximately 98 kilometres per hour. He was towing a boat. He recalled being overtaken by several vehicles, including a white Holden

Commodore, which overtook him at high speed, estimated to be well over 130 kilometres per hour.

43. He said that after overtaking him, the Holden Commodore maintained its high speed. He confirmed that at that time, there was no oncoming traffic, and he considered the overtaking manoeuvre as being controlled.
44. Approximately three minutes after being overtaken by the Holden Commodore, he arrived at the crash scene and saw smoke and the aftermath of the collision. The Holden Commodore was split into two parts and was on fire and the Toyota Hilux was overturned. Other motorists were parked up close by and assisting.
45. Kelly Fanning and Chelsea Smith live in Emerald and were travelling in a Toyota Landcruiser along the Capricorn Highway heading towards Rockhampton. Kelly Fanning was driving. In the vehicle also were two other younger members of their family.
46. They first noticed the white Holden Commodore parked on the left-hand side of the road in Comet, in the last parking area before exiting the town. Two men were seated in the front, but they could not recall seeing any children or other people with them. There were no other vehicles parked near the Holden Commodore.
47. Later, as they travelled along the highway, there were two other four wheel drive vehicles travelling ahead of them in the same direction. The Holden Commodore approached at speed from their rear and overtook them.
48. At that time, their vehicle was travelling at approximately 104 kilometres per hour, and they estimated the speed of the Holden Commodore to be somewhere in the vicinity of 150 to 160 kilometres per hour.
49. The overtaking took place on a straight section of the road before a bend. After rounding that bend, they saw the crash site. Their description of the scene was that the Toyota Hilux utility was upside down with the front of the Holden Commodore crushed and in front of the overturned Hilux. The back of the Holden Commodore was on the left-hand (northern) side of the road.

Autopsy examination

50. Subject to the provisions of the Act, orders were made on 21 July 2025 for an autopsy and autopsy testing of Mr Ranger, Mr Beitzel and the two children, Baylee and Chandler.
51. The type of examinations required were external and/or internal examinations to the extent necessary, as determined by the forensic pathologist. Those autopsies included an external examination of their bodies, including a CT scan, a review of the available information and associated toxicology testing.

Mr Ranger

52. At autopsy, there was evidence of complete incineration, with charring, extensive skin and muscle loss and multiple sites of acquired deformity attributed to both injury and incineration artefact.
53. The full body CT scan showed there was no evidence found to indicate coronary artery or systemic vascular calcification. It also showed evidence of multiple severe injuries including catastrophic craniofacial injuries, craniocervical junction injury with near complete transection at the brainstem, extensive rib fractures, midthoracic spine fracture distraction with spinal cord transection, cardiac rupture, thoracic aortic transection, transection of the left main bronchus, pulmonary lacerations, liver lacerations, and pelvic disruption. These injuries would have caused death instantaneously at the time of the collision.
54. Because Mr Ranger was the driver of the vehicle, consideration was given by the forensic pathologist as to whether an internal examination may be required. However, due to his young age, the absence of vascular calcification on CT scan, the circumstances given that excessive speed may have contributed to the collision, and the multiple catastrophic injuries sustained by him, it was not considered necessary to perform an internal examination to determine an opinion as to the probable cause of death.
55. In respect to the toxicology analysis, I have already indicated in these Findings that no alcohol was detected, however THC was detected at an approximate level of 0.04 mg/L which supports Ms Jenkins comments that they had smoked cannabis the night before.
56. When assessing the cause of Mr Ranger's death, the forensic pathologist opined that the sole cause was multiple injuries resulting from the motor vehicle accident.

Mr Beitzel

57. On examination, there was evidence of complete incineration, with charring, extensive skin and muscle loss and multiple sites of acquired deformity attributed to both injury and incineration artefact.
58. A full body CT scan showed evidence of multiple severe injuries including catastrophic craniofacial injuries with predominantly absent brain matter, rib and sternal fractures, cardiac rupture, left haemothorax, aortic laceration, thoracic spine fracture, and pelvic fractures. These injuries would have caused death instantaneously at the time of the collision.
59. A post-mortem sample of blood had been collected for full toxicology testing, and limited rapid toxicology testing for carbon monoxide shows a slightly elevated result (9% haemoglobin saturation), although below a toxic level. This result is favoured to be predominantly the result of long term tobacco smoking.

60. The toxicology results revealed the presence of THC at a level of 0.02 mg/L, and alcohol at a level of 21 mg/100mL indicating that sometime prior to his death he had consumed alcohol, and a cannabis based product.
61. In respect to his cause of death, the forensic pathologist opined that the sole cause was multiple injuries resulting from the motor vehicle accident.

Baylee

62. Externally, the autopsy revealed a severe open head injury with brain extrusion. There were multiple sites of injury on her body in the form of bruises, abrasions and occasional incised wounds, as well as abrasions on her lower torso which could be consistent with a seatbelt injury.
63. The post mortem CT scan showed evidence of multiple severe injuries including catastrophic head injury in the horizontal plane at the level of the mid-forehead and absence of intracranial contents, C6/7 fracture distraction and spinal cord transection, rib fractures, bilateral pneumothoraces, pelvic fracture, and left upper and lower limb fractures.
64. In the opinion of the forensic pathologist, those injuries experienced by Baylee would have caused instantaneous death at the time of the collision, and the cause of her death was multiple injuries resulting from the motor vehicle accident.

Chandler

65. On examination at autopsy, there was evidence of complete incineration, with charring, extensive skin and muscle loss and multiple sites of acquired deformity attributed to both injury and incineration artefact.
66. A full body CT scan showed evidence of multiple severe injuries including catastrophic head injury with severely comminuted craniofacial fractures, severe neck injury with fracture distraction of the cervical spine and near complete decapitation through the C2/3 level. Severe thoracic injury with extensive disruption of the anterior and superior thoracic wall, malposition and herniation of internal organs, and bilateral pelvic fractures.
67. The opinion of the forensic pathologist was that those injuries experienced by Chandler would have caused instantaneous death at the time of the collision, and the cause of his death was multiple injuries resulting from the motor vehicle accident.

Summary of autopsy findings

68. When carefully considering all of the findings at autopsy, the forensic pathologist's opinion as to the cause of death for all four persons was that they each experienced multiple injuries resulting from the motor vehicle accident. I accept those opinions.

Conclusions

69. Having regard to the information and evidence provided to me, I consider that I have sufficient information to make the necessary findings in respect to the deaths of Mr Ranger, Mr Beitzel, Baylee and Chandler.
70. Although I am satisfied that the very nature of this accident, and the death of two young children holds significant public interest, I am not satisfied that it would be in the public interest to hold an inquest into their deaths because a public hearing is unlikely to lead to recommendations that could assist to prevent similar deaths in the future, and there is no factual disputes or suspicious circumstances that are to be resolved through a court hearing.
71. In carrying out my role in undertaking a coronial investigation into their deaths, section 45 of the Act provides that I must, if possible, undertake a number of things and make findings (section 45(2) findings) about who the deceased persons were; how they died; when they died; where they died; and what caused their deaths.
72. In saying that, I accept the opinion of the forensic pathologist that the cause of each of their deaths was multiple injuries they experienced because of a motor vehicle collision.
73. I am also satisfied and so find that at the time of the collision, Mr Ranger was the driver of the Holden Commodore, and he was travelling in an easterly direction along the Capricornia Highway in the direction of his home in Blackwater.
74. I find that the weather and road conditions were not contributing factors to the accident, as it was a clear and sunny day with good visibility. Witnesses were able to see the road well ahead of them as they travelled the highway.
75. The highway consisted of a two lane sealed surface which was dry and in good condition. Notwithstanding that Mr Wilson described the road as poor, with dangerous driving behaviour from other motorists, including speeding and reckless overtaking, neither he nor the other witnesses using that section of highway at that time experienced any difficulties driving at or around the posted 100 kilometres per hour speed limit in that area. When taking all of that into account, I find that the road conditions did not contribute to the accident.
76. Just days prior to the accident, Mr Ranger re-registered the Holden Commodore. For that to occur, he was required to show that the vehicle was roadworthy and produce a Vehicle Safety Certificate to that effect. That certificate was issued on 16 July 2025 and lodged with the Department of Transport.
77. Therefore, I find that the vehicle passed a roadworthiness inspection, and at the time of the accident the vehicle was in sound mechanical condition.

78. I have given particular regard to the evidence provided to me from the forensic pathologist about the autopsy of Mr Ranger, along with his toxicology results. No alcohol was detected in Mr Ranger's toxicology results for his blood; therefore, I can satisfactorily rule out alcohol as a contributing factor to the manner of his driving which ultimately led to the fatal accident.
79. Within the toxicology results, a small quantity of THC was detected in his blood at an approximate level of 0.04mg/L. Because of the nature of Mr Ranger's body after the accident, the sample of his blood was obtained from his body bag, therefore raising a possibility of an over representation of THC.
80. Notwithstanding that, when taking into account the evidence that he had consumed cannabis the night prior to the accident, what cannot be discounted that this may have had a possible impact upon his behaviours such as risk taking, and judgement of the road conditions, although I accept that there is no evidence to substantiate that. Therefore, I am not inclined to make a finding that Mr Ranger's use of cannabis the night before the accident was a contributing factor to the collision.
81. In arriving at my findings, I also took into account there was no evidence of cardiovascular disease, along with the information about mental health, including a diagnosis of bipolar and anxiety; he had been prescribed medication for those conditions; and the anniversary of his brother's death took place two days prior to the accident which claimed Mr Ranger's death.
82. In respect to his physical health, the forensic pathologist detected the absence of vascular calcification on the CT scan, therefore allowing me to accept that a sudden lapse of control of the vehicle because of cardiovascular reasons was not a factor to be considered.
83. Returning to the toxicology analysis, this did not reveal the presence of any prescription medication. In that regard, the evidence does not support a finding that his mental health diagnosis was a contributing factor to the accident.
84. In respect to Mr Ranger's manner of driving on that day, I accept, and so find, that as he drove the Holden Commodore east along the Capricornia Highway, he drove at a speed that far exceeded the posted speed limit for that area. In doing that, he overtook a number of vehicles, and crossed over double white lines, and cut back across in front of vehicles. That sudden and rapid manoeuvre caused the Holden Commodore to noticeably "speed wobble". His manner of driving was described by other motorists as reckless and dangerous and having carefully assessed the contents of the FCU investigation report, I am satisfied that that term aptly identifies and describes his driving.
85. I now turn to discuss the children who were both seated in the backseat of the Holden Commodore, and whether they were suitably restrained as required by law within either an approved child restraint or a seat belt.

86. In Queensland, the law provides that because Mr Ranger's vehicle was moving, he was required to ensure that each of his passengers were wearing an approved seatbelt that is properly adjusted.¹ Baylee was aged seven, and from the evidence before me, the forensic pathologist observed injuries to her are consistent with having been caused by a seat belt. Witness evidence also suggests that at the accident scene, she was located in the rear sect of the vehicle, still strapped in her seatbelt.
87. Because Chandler was aged six, by law,² Mr Ranger was also required to ensure that Chandler was restrained within that vehicle in a properly fastened and adjusted Australian Standard approved child restraint. There was no evidence that he was restrained within that vehicle, and I find that at the time of the accident, he was not restrained.
88. In regard to Baylee, and whether she was suitably restrained in the rear seat of the Holden Commodore, she was aged seven. Therefore, in Queensland, children aged seven years and over may sit in a standard seat with an adult seatbelt or an approved booster seat. Before moving from a booster seat to a standard car seat, that could have only been done on the proviso that she able to sit with all of her back against the vehicle seat back; her knees were able to bend comfortably over the front edge of the vehicle seat; the lap belt sat low across her hip bones, touching her thighs; the sash (shoulder) belt sat across the middle of her shoulder, and not on her neck or out near her arm; and she would have been able to stay seated in that position for the whole trip.³
89. I have already pointed out the forensic pathologist's comments in respect to evidence of seatbelt bruising on Baylee, and witnesses at the incident scene observing that she was still strapped in her seat belt in the rear of section of the vehicle. When considering all of that, I am unable to definitively make a finding that she was not properly restrained as required by law.
90. Both Baylee and Chandler were rear seat passengers in the collision. Baylee was found still in her seatbelt in the rear section of the vehicle, and Chandler in the front part with Mr Ranger and Mr Beitzel. On my assessment of the evidence gathered by the FCU investigation, as well as the opinion expressed by the forensic pathologist as to the injuries suffered, and taking into account the catastrophic and violent nature of the collision with the Holden Commodore being ripped apart into two pieces, even if Chandler and Baylee had been restrained in the back seat as required by law it is extremely unlikely that they would have survived.
91. I am satisfied and so find that based on the evidence gathered during the FCU investigation that the fatal accident was caused by driver error on the part of Mr Ranger. The significant contributing factors were the excessive speed he drove the Holden Commodore and his loss of control of that vehicle.

¹ *Transport Operations (Road Use Management – Road Rules) 2009*, s 264A.

² *Transport Operations (Road Use Management – Road Rules) 2009*, s 266(2B).

³ Child restraints, children 7 years and over, Queensland Department of Transport, Road Rules for everyday driving, <https://www.qld.gov.au/transport/safety/rules/children/types>.

92. In respect to excessive speed, the yaw calculation determined by the FCU investigation shows the Holden Commodore was travelling at an estimated speed between 151 and 165 kilometres per hour, which significantly exceeded the posted speed limit of 100 kilometres per hour.
93. When Mr Ranger lost control of the Holden Commodore, the vehicle partially drifted off the left road shoulder and struck a guidepost. Following this, he applied a heavy right-hand steering input, causing the vehicle to rotate in a clockwise yaw. That loss of control resulted in the Holden Commodore crossing into the opposing lane, and in doing so, entered the westbound lane of the highway and collided with the oncoming Toyota Hilux containing Mr Wilson and Mr Green. The collision was catastrophic, with the impact splitting the Holden Commodore into two parts. Both vehicles caught on fire.
94. I find that excessive speed and Mr Ranger's failure to maintain control of the Holden Commodore are all indicators that his driving behaviour was the primary contributing factor to that accident.
95. In driving his vehicle in the manner in which he did, Mr Ranger showed scant regard for not only the safety of other road users, but very little respect for his own safety and well-being, as well as his passengers of which there were two very young children.

Findings required by section 45 of the Act

- Identity of the deceased** – Corey James Beitzel, Baylee Maree Jenkins, Shaun Michael Ranger and Chandler Kody Ranger.
- How the deceased died** – Whilst travelling along the Capricornia Highway in Central Queensland approximately 10 kilometres east of Comet, Shaun Michael Ranger drove a Holden Commodore at a speed estimated to be between 151 to 165 kilometres per hour. He lost control of the vehicle and collided with a Toyota Hilux travelling in the opposite direction. Resulting from that accident was the death of Mr Ranger, along with his passengers, Corey James Beitzel, Baylee Maree Jenkins and Chandler Kody Ranger who all died from multiple injuries they each suffered as a result of the motor vehicle accident.
- Place of death** – Capricorn Highway, 10 kilometres east of Comet, Queensland, Australia.
- Date of death** – 20 July 2025
- Cause of death** – Multiple injuries resulting from the motor vehicle accident.

96. I offer my sincerest condolences to the families of all involved and I close my investigation



Wayne Pennell
Mining and Resources Coroner and Northern Coroner