QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Peter Raymond Thistleton**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	26 June 2025
FILE NO(s):	2025/1290
FINDINGS OF:	Carol Lee, Coroner
CATCHWORDS:	CORONERS: Heavy Vehicles, Prime Mover and Two Trailers, Crash in context of Driver Fatigue, Failure to Wear Seat Belt, Speeding and Drug Driving.

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Introduction

Peter Raymond Thistleton (Peter) was born in Toowoomba on 3 June 1963 and died on 19 March 2025 at Burnett Highway between Burnett Highway and McCord Creek Road, Grosvenor.

Queensland Police Service (Police) reported Peter's death to the coroner because his death appeared to be a violent or unnatural death and fell within the definition of a reportable death in the *Coroners Act* 2003.

The role of a coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish facts, not to cast blame or determine criminal or civil liability.

Circumstances

Peter was a 61-year-old truck driver who resided at Monto with his spouse.

At approximately 04:45 hours on 19 March 2025, Peter was driving a prime mover (PM) (Heavy Vehicle registration XQ09KU) towing two trailers (Heavy Vehicle registrations of YQ08MC and YQ09MC), south along Burnett Highway towards Mundubbera, when the PM left the road and rolled over. A person who subsequently came across the crash called Emergency Services.

Queensland Fire and Rescue Service (QFRS), Queensland Ambulance Service (QAS) and Police arrived at the scene from approximately 05:05 hours, where they found the involved PM stationary in a u-shape with the two trailers still upright and the PM resting on the passenger side rolled over, similar to when a vehicle and trailer jack-knifes.

Peter was located unresponsive with his upper body protruding out of the driver's side window of the PM and his lower body pinned under the PM. His seat belt had been fastened behind him so to negate the activation of any seatbelt sensors during operation. With the seat belt remaining fastened and Peter having been ejected from the cab, Police formed the view that he was not wearing a seatbelt at the time of the crash. Peter was pronounced deceased by the attending QAS paramedics at 05:47 hours.

Upon further inspection of the PM, Police located a "*bong*" made out of an iced coffee bottle with green hose attached and a bowl containing what looked like cannabis remnants.

According to information given to Police, Peter had been suffering from asthma but had not been to a doctor since 2023. He was also a heavy drug user and regularly smoked cannabis.

Autopsy examination

An autopsy was ordered and performed. It comprised an external and internal examination (to the extent an internal examination was required to determine the cause of death), imaging, document review and toxicology studies.

The opinion of the forensic pathologist as to the cause of death is based on consideration of the circumstances of death and an autopsy including associated imaging and testing

The forensic pathologist summarised the findings at autopsy as follows:

1. External examination showed multiple injuries to the head, back and lower limbs. Injuries of the back (abrasions) were of ground impact-type. The injuries of the lower limbs were predominantly deep lacerations.
2. The major internal injuries were of the chest, pelvis and lower limbs including multiple rib fractures, haemopneumothoraces (right sided), pelvic and sacral fractures and associated soft tissue haemorrhage and multiple lacerations to the legs.
3. There was autopsy evidence of severe single vessel atherosclerotic coronary artery disease with 90% chronic occlusion. Autopsy did not show any evidence of acute coronary event such as thrombosis or ruptured atheromatous plaque in this case. In addition, there was evidence of smoking-related chronic lung disease (chronic obstructive pulmonary disease).
4. Histology cassettes were processed however, further processing and reporting were not performed.
5. Toxicology report showed absence of alcohol in blood and vitreous humour. Active ingredient of cannabis (THC) was detected from blood.

In summary, the forensic pathologist opined that death was due to multiple injuries. Injuries were consistent with Peter being ejected from the vehicle and landing on the ground. Severity of the injuries was such that rapid death would be expected.

In the opinion of the forensic pathologist, the cause of death was:

1(a). Multiple injuries, *due to or as a consequence of*
1(b). Motor vehicle collision (driver).
Other significant conditions
2. Coronary atherosclerosis, chronic obstructive pulmonary disease.

Investigation

Police officers from the Forensic Crash Unit (FCU) attended the scene and undertook an investigation. Following completion of the investigation, findings and an opinion was provided; a relevant summary of which appears as follows:

Units Involved

1. The vehicle is a 2020 Scania R620 PM with Heavy Vehicle registration XQ09KU, registered to Bailey Creek Piggeries.
2. The PM was towing 2 independent trailers. Trailer A is a Moore 2021 semi-trailer with Atm over 4.ST registration YQ08MC. Trailer B is a Moore 2021 semi-trailer with Atm over 4.ST registration YQ09MC. Both trailers have WABCO logic modules.
3. The trailers were not loaded.
4. Peter was the sole driver at the time of the crash. He held a Queensland driver's license (open with the condition of corrective lenses). He had 26 entries in his driving history going back to 1990. Of relevance from this history were incidents of contravening fatigue management guidelines (25 February 2025 & 13 June 2012), driver use mobile phone (20 December 2024), not wearing seatbelt (25 March 2022), drive with relevant drug present (2018 & 2013), and careless driving (2012 & 2013).

Incident Description

5. The incident location was on the Burnett Highway between Malmoe and Grosvenor Queensland, approximate GPS -25.442920, 151.196085.
6. The PM was travelling south from Monto when it negotiated a slight right bend at the top of a hill descent, when it appears to have partially left the sealed road surface with evidence of left-hand tyres on the grassed and dirt verge sloping down away from the sealed road. It then appears to have attempted to correct itself and returned to the sealed road surface.
7. The PM continued onto the right-hand inclined verge where it straightened parallel to the road, impacted several roadside trees before attempting to return left to the sealed road and before colliding with a recessed ditch.
8. The A Trailer broke the hitch and pushed forward under continued momentum rolling the PM, which twisted to the left under yaw and rolled onto the right-hand side.
9. The A Trailer pushed up, on top of the flipped left-hand rear of the PM, running roadside along the drainage ditch. This caused Peter to be ejected from the driver's window and being pinned under the cab.
10. The B Trailer yawed, rotating anti-clockwise and the rear wheels showed clear gouging consistent with striations on the sealed road evident of sideways motion.

Crash scene from top of decline facing South.

Scene Examination

11. The scene is an approximately 200-metre-long stretch of a default 100 km speed zone sealed bitumen on the Burnett Highway running north/south with a single lane in each direction separated by a continuous double white centre line and of a slight gradient. The PM was approaching from the north, travelling south. At the top of the incline the road bends slightly to the right (less than 30 degrees).
12. On the eastern side of the road is a steep grassed embankment varying from around 20 to 30 degrees which drops away to approximately 2 metres lower than the road height up until a property fence line and tree line.
13. The western side of the road has a gentle sloping grassed and dirt verge from the top of the incline, which then becomes raised above the height of road consisting of dirt and scrubby tree vegetation about halfway down the hill. This raised section then ends with a half metre depression on the flat at the base of the hill directly beside the edge of sealed road, possibly for roadside drainage or as a result of erosion.

14. Transfer from a tyre contacting the reflector post immediately prior to damage to the edge of sealed surface was observed with disturbance in the grass along the edge of the inclined verge several metres prior to the first observations of wheel tracks present in the grassed verge.

Scuff indicating first observed point of contact on roadside reflector post.

15. A roadside reflector post was also observed lying several metres down the inclined verge from where it had been removed from the edge of sealed surface by the impact with the PM. Wheel marks in the vegetation were observed, marked and followed for approximately 50 metres.
16. A clear point of re-entry to the sealed road surface was identified further down the incline. This was evidenced by significant gouging on the edge of sealed surface and was consistent with tyre marks from the vegetation lining up with tyre marks on the road at this point.
17. Multiple tyre marks consistent with dual double rear axles of the trailers and PM were observed from this point which tracked up to the point of termination where the axles of the PM and A Trailer left the sealed surface on the western edge, and the B Trailer remained in situ across the roadway.
18. The PM was located on its right side, with the driver pinned from the stomach down underneath the front right corner of the side of the cab around the A pillar to driver's door.
19. A small tree with a primary trunk of about 4 metres in height and a 10-centimetre circumference at thickest point with a substantive lower trunk base, was laying partially in front of the PM on the road.
20. The cab of the vehicle showed indications of a traumatic impact, including energy drinks, clothing and smoking implements strewn around.

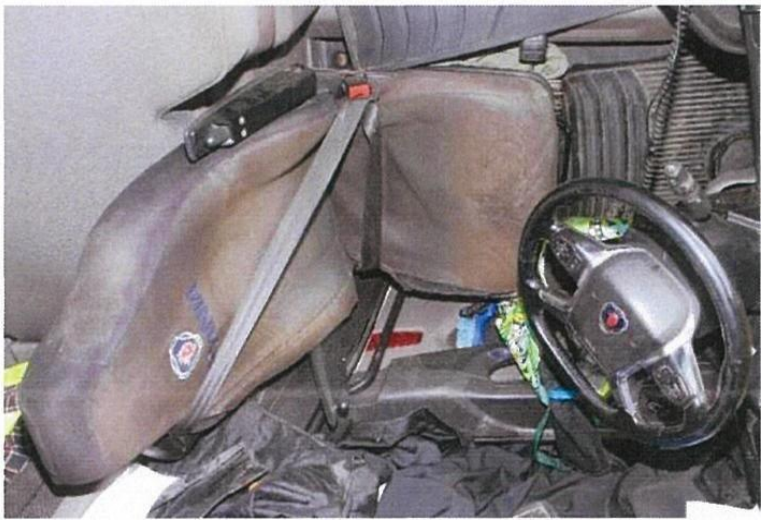
Forensic scene map and overview breakdown.

21. The road is approximately 10 metres wide from edge of pavement (EP) to EP with two standard 3.5-metre-wide lanes. Fog line (FL) to EP varies from approximately 1.0-1.5 metres (1.25 metres avg). The distance measured of tyre marks from where PM left the eastern EP until re-entered EP approximately 40 metres.
22. Distance measured from where the PM left the EP until Trailer B re-entered the EP is approximately 82 metres.

Track of prime mover through tyre marks

Track of A trailer through tyre marks

Track of B trailer through tyre marks



Cab driver's seat belt.

Image showing the western edge roadside drainage and wheel marks through vegetation with tree damage leading to drainage ditch roadside bottom of decline western side.

Wheel tracks crossing bitumen east to west close up.
Right to left – PM, Trailer A, Trailer B.

Wheel tracks re-entering bitumen close up.
Right to left – Trailer A, Trailer B.

Vehicle Examination

23. The PM exhibited minor damage to the lower front end, with scrapes and impact damage seen on the front right comer spreading from the headlight assembly towards the number plate. This damage bore the transfer of red dirt and dust and would be consistent with an impact such would be expected when the truck impacted the dirt hillside and subsequent ditch of the western side of the road.

24. The undercarriage appeared free of any substantive damage with the front wheels and steering assembly appearing damaged but intact. The windscreen and roof displayed damage consistent with the impact of a rollover.

25. Some areas of scrapes and transfer were seen on the undercarriage of the PM consistent with low points making contact with hard surfaces.

Image showing scrapes and damaged undercarriage of PM from contact & Image showing A Trailer free of coupling resting on rear left of PM.

26. The rear axle seemed to have slightly rotated out of true to the right along the horizontal axis which would be consistent with the weight and forces expected from Trailer A breaking its coupling and rolling forward over the rear of the PM to finish suspended at the front with

the weight resting on the PM's rear wheels and its own rear axle.

27. The sunroof was absent from its fittings (removed by QFRS) and side curtain airbags appeared to have been deployed.
28. The driver's seat belt was plugged in and tight across the seat indicating it was not worn.
29. A search of the cab revealed a homemade water pipe (bong) and a small quantity of cannabis in a tobacco tin.
30. The A Trailer showed signs of usual wear and tear from operational use. The coupling appeared intact. The rear 3 sets of dual tyres and wheels appeared whole and intact, with some minor damage in a deformation to the mid right wheel arch.
31. Trailer B appeared mostly undamaged from the right side. Its final position was on a slight downward angle towards the hitching point with Trailer A. The rear axle was off the ground, with the balance of weight primarily resting on the first axle.
32. The rear of Trailer B showed signs of wear and use but no significant damage.
33. The left-hand side of Trailer B showed a significant depression in line with the rear left corner of Trailer A.
34. There were an upper and lower indentation, with vertical creasing in the metal consistent with the reinforced corner edge of the rear of Trailer A.
35. This damage was consistent with the left side of Trailer B attempting to wrap around the rear right corner of Trailer A, at a point past a 90-degree yaw angle.
36. Trailer B tyres showed lateral scoring of the rubber consistent with sideways drag under forward momentum.

Mechanical Inspection

37. A forensic mechanical inspection was requested for the PM and both trailer units with a download of truck and trailer modules.
38. A complete accurate assessment as to the PM's overall mechanical condition was unable to be made due to the extent of impact damage it had sustained. However, there were no mechanical defects found by the assessor that could have contributed to the cause of any incident.
39. A mechanical inspection was undertaken on the white 2021 Moore Trailer Road train B/double Trailer 0TH Reg #YQ08MC. It was found that it appeared to be in a satisfactory mechanical condition. There were no mechanical defects found by the assessor that could have contributed to the cause of any incident. The third axle left-side inner tyre was found to be devoid of sufficient tread which is unsatisfactory.
40. It was advised that a brake roller test be performed to determine braking system efficiency.
41. A mechanical inspection was undertaken on the white 2021 Moore Trailers Road train B/double Trailer 0TH Reg #YQ09MC. It was found that it appeared to be in a satisfactory mechanical condition. There were no mechanical defects found by the assessor that could have contributed to the cause of any incident.
42. It was advised that a brake roller test be performed to determine braking system efficiency.
43. Both trailers passed dynamic and static brake testing; the results of which were reported as follows:
    a. Trailer A performed dynamic brake tests with an average efficiency across the 3 axles of 87% and a static efficiency of 57%.
    b. Trailer B performed with an average of 57% efficiency across the 3 axles and 32% static efficiency across the 3 axles.

Toxicology

44. Toxicological results from the autopsy indicate that there was 0.005mg/L of △9 tetrahydrocannabinol (THC) present in Peter's blood.
45. Alcohol or other drugs were not detected.

Interviews

46. According to information given to the investigating FCU officer:
    a. The trailers used by Peter were known to brake involuntarily when not carrying loads.
    b. The PM had been involved in a crash several months prior (17 December 2024) and it was believed the repairs had not been done properly.
    c. Peter had been unwell and struggling with sleep and had recently changed his work schedule to more daylight driving to minimise fatigue issues.
    d. Peter was a habitual smoker of marijuana, had smoked the previous day and likely that morning prior to setting out in the truck.
    e. He suffered from undiagnosed sleep apnoea and was also using a Ventolin puffer recently as he was struggling with shortness of breath.
    f. In 2015 Peter became ill and was taken to hospital by QAS where sleep tests were done. As a result of these tests, Peter came to possess a sleep apnoea machine, however he refused to use it and instead relied on a puffer and marijuana to self--medicate his breathing and sleep/ fatigue difficulties.

Additional investigations

47. A search of Peter's phone was conducted however nil relevant GPS data was obtained, and nil call or message logs indicate the phone was in use or being used at the estimated time of the crash.
48. There was nil CCTV in the area of the incident, or dash camera or guardian fitted to the PM truck.
49. There were nil witnesses to the incident for additional dash camera footage.
50. Peter's driving history showed:
    a. He was a career truck driver based out of Monto working for Bailey Creek Piggeries, usually hauling grain. His family reported he had been involved in a previous truck accident in 2013 (QP1300415964) where he was driving a B-Double and drifted off the road before tipping over after attempting to recover control of the vehicle.
    b. In 2017, Peter was charged and convicted of driving with a relevant drug present in his blood or saliva- cannabis. His family reported that he was a habitual user of cannabis and had most likely used cannabis the morning of his death.
51. Peter's logbook/work diary showed:
    a. It was incomplete on the day of the incident, with no start time documented, as is required.
    b. His work history appears compliant with standard fatigue guidelines, however small errors in timings and overall count of work hours and rest hours can be seen. It is impossible to know if this is due to unintentional mathematical mistakes on Peter's part, or due to retrospectively completing the time sheet and making errors estimating figures. When looking at the trips described in the logs, the timings appear consistent, however do not show any significant variance accounting for traffic, weather, diversions etc.
    c. Peter's logbook was inspected by the National Heavy Vehicle Regulator on 25 February 2025, with nil major inconsistencies identified.
    d. Peter was a regular driver of the PM, however there were no records in the truck indicating how often he used the trailers involved in the crash. Investigating Police located a handwritten notebook with his work diary containing notes indicating he had used the trailers on multiple occasions.
    e. The routes Peter took to Pinkenba and other destinations such as St Ruth, Kilkivan, Ban Ban Springs and Caboolture would all most likely have been accessed from his depot at Mulgildie via the Burnett Highway to any connection

South of Mundubbera. Peter would have been very familiar with the road in both directions of travel at various times of day.

52. A download of the WABCO modules installed on the trailers was performed to determine whether there was any existing issue not initially visible in the forensic mechanical inspection that could potentially have contributed to the accident.
53. The modules record data relating to the operational use and ongoing maintenance of the trailers. This data also includes error messages which are recorded in a Diagnostic Memory Log.
54. An analysis of the download data primarily indicates that both trailers registered multiple top brake application speeds well above signed speed limits over the duration of the recorded memory period, from 2022 up until date of incident.
55. Some high recorded speeds of note for Trailer A, are 9 February 2025 (120km/h), 24 February 2025 (119km/h), 25 February 2025 (128km/h), 3 March 2025 (119km/h), 4 March 2025 (123km/h), 11 March 2025 (123km/h).
56. Some high recorded speeds of note for Trailer B, are 1 August 2024 (125km/h), 7 November 2024 (124km/h), 12 November 2024 (126km/h) 4 March 2025 (122km/h), 11 March 2025 (122km/h).
57. In Queensland, heavy vehicles (over 12 tons GYM or buses over 5 tons GYM) are generally limited to a maximum speed of 100km/h, regardless of posted speed limits. Road trains, however, are restricted to a maximum speed of 90km/h. Heavy vehicles are required to be fitted with speed limiters set at this maximum speed.
58. These extremely high maximum braking speeds recorded so recurrently may be indicative of a pattern of driving behaviour suggesting habitual speeding in the use of both trailers.
59. Unless the module was programmed with incorrect specifications regarding tyre size and the number of pole wheel teeth in the exciter wheel ring, then the recorded speeds would be inaccurate, however there is no evidence of this with the data showing correct standard sizes recorded for both trailers.
60. There are multiple errors observed on the Diagnostic Memory Log for both trailers.
61. A "Supply pressure sensor" fault is observed occurring in both trailers. The fault message indicates that "automatic braking can be triggered" because of this fault. This fault was last recorded in Trailer B's Diagnostic Memory Log on 12 March 2025.
62. Clarification was obtained from the manufacturer regarding the data regarding these faults and their effects/implications. If the brakes are pressed and the system is registering an RSS (Roll Stability System) event the module may bring ABS (Anti-lock Braking System) on such as happens when the heavy vehicle comers too fast and the driver touches the brake pedal.
63. When the system voltage drops below operating requirements the spring brakes may activate without the brake pedal being pressed.
64. There are several supply pressure and power supply faults observed in the diagnostic memory logs indicating a recurring issue. The lack of date and time associated with all fault logs is also attributed to the power supply not being correctly installed or the units being used with a PM that is not an ABS system.
65. There is no recorded data in the download indicating that the brakes were activated due to a fault or error related to ABS, BBS (Electronic Braking System), RSS or any other intelligent system installed and being monitored on the date of incident.
66. There was no indication from evidence observed at the scene that would corroborate an unplanned trailer braking episode such as a spring brake or RSS episode occurred to cause the vehicle to leave the roadway.
67. The PM and trailers leaving the roadway onto the embankment would likely have triggered an RSS event.

68. In an RSS event, sensors measure lateral acceleration, vehicle speed and wheel slip to assess potential for rollover. The system will then activate the brakes on the outside wheels to counteract roll force.
69. Simultaneously, the braking force is managed to prevent wheel lock up and assist the driver in maintaining control of the vehicle in conjunction with ABS and ESC systems. The RSS systems may also apply the independent trailer brakes to stabilize the entire joined vehicle length.
70. The last log entries from the system in this matter are from the previous day. The lack of any recorded data on the date of incident was deemed to be due to the unit not being supplied with power from the outset of the trip; or because a power related issue occurred during the impact which prevented all data being recorded from being stored on the modules.
71. The investigating FCU officer's opinion as to the cause of the incident was as follows:
    a. At least 3 of the fatal 5 offences identified as being most prominent in road related deaths appear to be present in this incident - drug driving, fatigue, failure to wear a seatbelt.
    b. Peter's family reported he had recently been experiencing breathing issues and was having disrupted sleep as a result of being short of breath, causing him to wake every 30 minutes or so, most likely resulting in an ever-increasing sleep deficit. Peter refused to see a health professional and his use of his Ventolin puffer and marijuana in the evening was his own attempt to cope.
    c. His colleague and family reported that Peter was trying to be conscientious as he knew he had fatigue related issues with late evening and early morning driving, and so he had changed his work activities from night drives to day shift drives where he believed he would be less affected by fatigue.
    d. The cumulative effects of ongoing fatigue are documented as manifesting as an increasing impairment and reduction in a driver's physical and cognitive abilities, concentration, decision making, reaction time and overall driving performance.
    e. Peter was potentially suffering from chronic fatigue due to recent difficulties with his breathing interrupting his sleep. His current and ongoing health issues were known to his family and his colleague, and with appropriate information and incentive he could have addressed these issues with the assistance of appropriate medical intervention.
    f. In his physical state on the date of incident, it is believed that Peter was potentially suffering from a sleep deficit and entered into a microsleep in which he failed to successfully negotiate the slight bend into the top of the straight decline at the crash site.
    g. Peter must have become aware of the vehicles leaving the road and the wheel tracks indicate he subsequently tried to correct the steering and return to the sealed road before the trailers could roll or slide down the eastern verge.
    h. While attempting to bring both trailers back onto the road, the PM has crossed over the entirety of both lanes and then onto the western verge and into the tree line.
    i. Despite the PM impacting several small trees, the PM had begun angling back toward the sealed road as the ground surface deteriorated into a rocky depression (ditch) at the base of the decline.
    j. The impact of the PM entering the ditch at an angle attempting to veer left onto the sealed road was sufficient to shear all the hitch attachment bolts and free the A Trailer and the continued forward momentum of Trailer A has rolled it up and onto the PM as it rolled on the vertical axis onto its right side.
    k. At this point if Peter was wearing his seatbelt, he would not have been ejected from the driver's window and likely would have survived with the activation of the side curtain air bags.

l. In the opinion of the investigating FCU officer, the scene evidence therefore supports the conclusion that the crash was the likely result of driver inattention. This inattentiveness was most likely a fatigue blackout (microslip) experienced by Peter as he crested the rise and began the slight right bend down the decline heading south at the accident site at around 04:45 hours.
m. Physical and scene evidence does not substantiate driver distraction due to mobile phone use, nor does it substantiate a mechanical malfunction capable of causing the PM to leave the road in the manner observed.
n. The area was well lit with nil street lighting however the truck lights were functional and sufficient to provide adequate illumination of the road and area.
o. The scene evidence shows the PM drift off the sealed bitumen at the top of the decline, with visible wheel tracks in the grassed verge observed from the initial evidence point.
p. There is no evidence of trailer lock ups, or any malfunction or mechanical failure in the trailer ABS / EBS contributing to the PM leaving he sealed road onto the verge at the top of the hill.
q. The tyre tracks observed are consistent with the left-hand wheel track of the steers and Trailer A and B following the angle of exit of the PM off the sealed bitumen with slightly increasing margins down the embankment, as would be expected to be seen in a series of vehicles with tow in this manner.
r. The PM driver has then made a deliberate attempt to correct the left drift of the vehicles off the road and has veered right and re-entered the sealed bitumen, with gouging in the bitumen edge providing continuity of tyre marks in vegetation back onto the sealed road surface.
s. The angle of tread marks across the road from left to right indicates a path that the PM traversed the width of the road and into the vegetated edge on the western verge.
t. Tyre marks in the vegetation on the western verge are consistent with the PM straightening to parallel with the road and continuing for approximately 20-30 metres.
u. The PM was then attempting to veer left and re-enter the sealed bitumen until the it has fallen into the western roadside ditch and violently uncoupled from Trailer A.
v. When breaking free, the forward momentum of Trailer A has carried the front up and onto the rear of the PM, rolling the truck onto its right side. Tyre evidence clearly shows Trailer B was following in the same path as both preceding vehicles on a slightly lower track whilst under yaw until this point.
w. Upon the impact of Trailer A breaking free, Trailer B has jack-knifed with the rear end weight bringing the yaw momentum rotating forwards towards the left side (clockwise). This caused the observed impact depression on Trailer B's left side from the collision of rear left trailer.
x. Significant striations and gouging visible on the sealed bitumen and the tyres themselves indicating forward motion of the tyres along a sideways orientation across the bitumen surface corroborate the track of Trailer B as it yaw rotated to its final position.
y. The driver was not secured by his seat belt and is believed to have been ejected from the cab of the PM out the driver's window at impact of Trailer A breaking free of the hitch and twisting and rolling the PM on the vertical axis as it pushed forward under momentum.
z. It is the opinion of the investigating FCU officer that had Peter been wearing his seat belt he would not have been ejected from the window and would likely have survived.
aa. The investigation identified a number of considerations:

i. Ongoing fatigue and the lack of medical assistance sought by Peter for his sleep apnoea.
ii. Speeding observed in the module download data.
iii. The lack of transparency in the required filling out of logbook entries to quantify work and rest time during heavy vehicle operations.
iv. The practice of driving with the seatbelt engaged but not worn so that no protection is given to the occupant.

bb. It is the opinion of the investigating FCU officer that these issues of fatigue, speeding and not wearing a seatbelt are contributing factors. Had these contributing factors been identified and addressed, then the accident would either not have occurred, or not potentially resulting in a fatality.

72. Consequently, the investigating FCU officer made the following determinations:
    a. Given the circumstances, no charges are under consideration by Police.
    b. No issues are identified.
    c. Proposed recommendations:
        i. A considered combination of education, mandated use of available technology and ensuring compliance with established laws and procedures could have prevented the loss of life in this incident.
        ii. The vehicle was not fitted with any driver monitoring devices such as a guardian system, nor did it have any vehicle monitoring systems such as front, rear and side cameras.
        iii. A guardian - originally known as a Driver State Sensor (DSS) uses a combination of sensor monitors including a dash mounted unit that monitors a driver's face for eye closure and tracks head movements. The inclusion of a guardian system would have provided real time audio, visual and vibration alerts to inform the driver of detection of his fatigue or distraction. All data is stored for analysis and transmitted via an in-vehicle modem without human involvement. A 2017 study showed a 66% reduction in fatigue related incidents and a 94% reduction when in-cabin alerts were provided in real time to the driver. In 2024, third generation guardian units were claimed to reduce fatigue related driving risk by 94%. Peter was an experienced heavy vehicle driver who had previously been involved in a fatigue or distraction related heavy vehicle rollover in 2013. If a Guardian system was fitted to the PM, it would have alerted Peter and potentially prevented the loss of his life that day.
        iv. The failure to accurately record logbook details in this instance is potentially indicative of a known patten of behaviour within the trucking and freight transport industry where drivers often complete inaccurate or fabricated daily entry details after conclusion of the drive to ensure they comply with established fatigue regulations. The introduction of phone or tablet application Heavy Vehicle electronic logbooks has begun to address this issue, however neither Peter nor his employer were yet using this available technology. The electronic logbook entries are made on the device through the application, and are tamper proof, can be linked to GPS and must be completed at the required times to ensure digital noncompliance warnings are not forwarded to the relevant agencies in oversight.
        v. Heavy vehicle drivers be given education regarding the dangers of sleep deficits, and poor health whilst driving.
        vi. Appropriate technology be utilized for improving the safety of heavy vehicle drivers and other road users, with tamper proof front, side and rear vehicle recording cameras, as well as DSS systems be mandated as compulsory for all heavy vehicles.

vii. Adoption of electronic logbook systems for reporting and monitoring compliance of drivers and their employer companies with established fatigue management regulations and guidelines be mandated.
viii. This would assist to reduce noncompliance and assist ease of monitoring by employers and relevant regulatory bodies.

Finally, I note there has been no indication by Police (including FCU) or notification from the Office of Industrial Relations of any Workplace Health and Safety investigation occurring as a result of this incident.

Conclusion

After considering the material obtained during the coronial investigation, I consider that I have sufficient information to make the necessary findings in relation to Peter's death. I am not satisfied that it is in the public interest to hold an Inquest as, I am of the view that drawing attention to the circumstances of this death is unlikely to prevent deaths in similar circumstances happening in the future. There is also no uncertainty or conflict of evidence as to justify the use of the judicial forensic process and no suspicious circumstances that have not been resolved or resulted in criminal charges. On that basis I have determined that an Inquest is not required.

I accept the forensic pathologist's opinion as to the cause of death and find that the cause of Peter's death was:

1(a). Multiple injuries *due to or as a consequence of*
1(b). Motor vehicle collision (driver).
Other significant conditions
2. Coronary atherosclerosis, chronic obstructive pulmonary disease.

I also accept the findings and opinion of the FCU and find that Peter's life tragically ended prematurely in a crash which occurred whilst operating a heavy vehicle with trailers on a highway in the early morning of 19 March 2025, as a result of a combination of fatigue, speeding, failure to wear a seat belt and drug driving. Beyond these causal factors, I note the investigating FCU officer's recommendations to the industry and the regulators, with the aim of putting in place various strategies to minimise a similar tragic incident from occurring again in the future, which I trust will be carefully considered by the National Heavy Vehicle Regulator and the Department of Main Roads and Transport[1].

I extend my condolences to Peter's family and friends for their loss.

Findings required by s.45

Identity of the deceased – Peter Raymond Thistleton

How he died – At approximately 04:45 hours on 19 March 2025, Peter was driving a prime mover (Heavy Vehicle registration XQ09KU) towing two trailers (Heavy Vehicle registrations of YQ08MC and YQ09MC), south along Burnett Highway towards Mundubbera, when the prime mover left the road and rolled over. Queensland Fire and Rescue Service , Queensland Ambulance Service and Police arrived at the scene from approximately 05:05 hours, where they found the involved vehicle stationary in a u-shape with

[1] Both entities of which have been provided with a copy of these findings.

the two trailers still upright and the prime mover resting on the passenger side rolled over. Peter was located unresponsive with his upper body protruding out of the driver's side window of the prime mover and his lower body pinned underneath. Peter was pronounced deceased by the attending paramedics at 05:47 hours.

Place of death – Burnett Highway between Burnett Highway and McCord Creek Road GROSVENOR QLD 4627 AUSTRALIA

Date of death– 19/03/2025

Cause of death–

1(a). Multiple injuries
1(b). Motor vehicle collision (driver)
Other significant conditions
2. Coronary atherosclerosis, chronic obstructive pulmonary disease

I close the investigations.

Carol Lee
Coroner
CORONERS COURT OF QUEENSLAND
26 June 2025