



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Arie Hirdansyah Putra
TITLE OF COURT:	Coroners Court
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REPRESENTATION:

Counsel Assisting:

Ms D Palmer.

Department of Transport and Main Roads: Mr P A Crofts.

Mr Peak:

Mr C Lumme of Lumme
and Associates.

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Introduction

1. Arie Hirdansyah Putra was a 29 year old Indonesian national who died in a motor vehicle collision on the New England Highway at Stanthorpe on the night of 22 March 2021. Mr Putra was driving home from work with his partner in heavy rain when their vehicle was struck by a laden B-double combination travelling in the opposite direction.
2. Mr Putra had been in Queensland since the end of 2019 on a working holiday visa, joining his older brother who had been living and working in Queensland for several years. He was a young man with dreams and determination to achieve them. Media reporting of Mr Putra's death describes him as an extremely hard working young man who had set clear goals for himself. This was his first time living far away from his parents. He was planning to return to Indonesia to surprise them before deciding whether to apply for a third year of the working holiday visa program. He is remembered as sensitive, caring and very considerate young man who enjoyed cooking. He and his partner were employed by Sweet Strawberry Runners in Stanthorpe performing agricultural work for their visas.
3. The Queensland Police Service Forensic Crash Unit investigated the collision. The forensic crash investigation identified the B-double combination's loss of traction with the wet road surface, and consequently, loss of directional stability, as the main causal factor in the collision. It identified factors including the truck driver's speed and manner of driving in heavy rain, the trailers' Electronic Braking System (EBS) not operating as intended, water pooling on the road and the potential impact of the trailer combination not being fully loaded as possible contributory factors leading to loss of traction and jack-knifing. No criminal charges were laid in respect of the collision and Mr Putra's death.
4. As at 22 March 2021 the Queensland Department of Transport & Main Roads (DTMR) was, by way of a service level agreement with the National Heavy Vehicle Regulator (NHVR), responsible for providing heavy vehicle on-road compliance and regulatory enforcement activities under the Heavy Vehicle National Law. DTMR did not take any regulatory action in respect of the collision. However, DTMR engineers assessed the road infrastructure at the collision site, identifying road surface drainage issues at the nearby intersection. The findings and recommendations arising from this assessment informed the coronial investigation.
5. Coronial autopsy determined the cause of Mr Putra's death to be traumatic asphyxia caused by the collision.
6. Mr Putra's death was a devastating loss for his family, friends and work colleagues. The collision was also extremely traumatic for his partner who survived the collision, the driver of the B-double combination and the first response police officers.

7. The inquest examined:

- (a) the findings required by s.45(2) of the *Coroners Act 2003*
 - (b) the nature and extent of all factors, including the prevailing conditions, and any human or mechanical factors, that caused or contributed to the Iveco Powerstar, Victorian registration 1AF1VV, colliding with the Honda Civic, Queensland registration 273ZIA
 - (c) the nature and extent of any safety measures that may have prevented or reduced the risk of the collision occurring in the prevailing conditions; and
 - (d) whether there are any recommendations that might be made that might prevent deaths from occurring in similar circumstances in the future.
8. My role as Coroner is to independently investigate Mr Putra's death to make findings about his identity, the medical cause of his death and when, where, and how he died. The Coroners Act prevents me from determining criminal or civil liability or regulatory consequences for his death.
9. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*¹ standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for me to be sufficiently satisfied on the balance of probabilities that the issue has been proven.
10. I may, where appropriate, comment on matters connected with Mr Putra's death and make preventative recommendations concerning public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.
11. The circumstances in which Mr Putra died highlight the critical role that ABS/EBS technologies play in supporting heavy vehicle drivers to maintain stability and control particularly in emergency braking situations.

Road geometry and infrastructure at the collision location

12. The section of the New England Highway where the collision occurred is a two lane-road traversing a general north-south direction between Warwick to the north and the New South Wales border as Wallangarra to the south. It passes to the west of Stanthorpe through a formed bypass around the town where the road orientates to a more east-west direction at the collision location.
13. There is an offset cross intersection with Caves Road to the north and McGlew Road to the south with dedicated turning lanes both left and right.

¹ *Briginshaw v Briginshaw* (138) 60 CLR 336.

14. The highway and the intersection were not lit by street lighting and there was no other ambient lighting nearby as it is not a built up area.
15. The collision occurred approximately 150 metres into a straight and flat section of highway coming out of a large radius righthand bend. Mr Putra's Honda Civic was approaching the location in an easterly direction. The B-double combination was approaching in a westerly direction. This path of travel involved the B-double combination cresting a gentle hill about 1.6 kilometres before the collision location and descend into an open righthand bend about 330 metres from where the collision occurred.
16. At the time of the collision, there was formed guttering on the corners of the intersection but not along the highway.
17. There was a grassed embankment on both sides of the road with a steep upgrade on the northern side.
18. The signed speed limit was 100km/hr.
19. There was no significant crash history at this location before the collision and no prior reported incidents of vehicles losing traction in wet conditions.
20. The inquest considered the extent to which road surface drainage issues may have played a role in the collision.

The B-double combination

21. The B-double combination comprised a white 2013 Iveco Powerstar 72000 prime mover (Victorian registration 1AF1VV), operated by Datspares Transport², towing two laden 2019 Top Start curtain side trailers (Victorian registration YV21AY and YV30AY) in a nine-axle B-double configuration. Datspares Transport was not previously known to DTMR. NVHR documented 172 intercepts of various registration plates linked to A Black Comet Pty Ltd, none of which resulted in any regulatory action against the company. Neither the prime mover nor the trailers were the subject of a defect notice prior to the collision.
22. The B-double combination had a maximum Gross Combination Mass (GCM) of 62.5 tonnes. At the time of the collision, it was carrying about 20 tonnes of bulk sugar and a quantity of aerosols.
23. The prime mover was fitted with an Anti-Lock Braking System (ABS).
24. The trailers were both new when hired to Datspares Transport by Top Start Hire Pty Ltd in September 2019 and July 2020. A Black Comet Pty Ltd was responsible for maintaining the trailers under the hire agreement.

² A Black Comet Pty Ltd as Trustee for the Murphy Family Trust was the registered holder of the business name Datspares Transport (ABN 89 542 409 758).

25. Each trailer was fitted with a WABCO Smart Braking System. This is a sophisticated Electronic Braking System (EBS) with multiple functions including electronic roll stability control. It uses wheel sensors to monitor wheel speeds and communicate with an Electronic Control Unit which signals the distribution of air pressure from the braking system to try and maintain stability. The system also has Anti-Lock Braking control, load sensing and other functions.
26. The WABCO Smart Braking System is powered by the prime mover via a coiled connector using a dedicated plug and socket. Without power, the EBS does not work, reverting the trailers to the conventional pneumatic braking system requiring driver input.
27. The inquest examined whether the trailers' EBS was connected to the prime mover and powered at the time of the collision and whether, if operating properly, it could have stopped the B-double combination jack-knifing.

The truck driver

28. Travis Peak, an experienced interstate truck driver of over 20 years, was driving the B-double combination. He had been driving full time for Datspares Transport for between six to twelve months. He was familiar with the heavy vehicle combination. He was not previously known to the DTMR or the NHVR for any serious infringements.
29. The inquest considered whether Mr Peak's manner of driving caused or contributed to the collision.

The collision

30. Mr Peak had driven the B-double combination to Brisbane after departing the Datspares Transport depot in Clayton, Victoria on the afternoon of 20 March 2021. He departed Acacia Ridge with a load of bulk sugar and aerosols at around 8:00pm on 22 March 2021 to return to Victoria. There is no concern that driver fatigue played a role in the collision.
31. There was a widespread significant weather event affecting large parts of Queensland and New South Wales with flooding closing the Pacific Highway in New South Wales. This meant interstate traffic could only use an inland route that night. Local Stanthorpe police anticipated this would increase the volume of heavy vehicle traffic on the New England Highway.
32. Mr Peak had been driving for about two-and-a-half hours immediately prior to the collision. It was raining heavily as he was travelling west along the New England Highway approaching the intersection with Caves Road and McGlews Road at Stanthorpe. At the same time, Mr Putra was driving the Honda Civic in an easterly direction towards Stanthorpe.

33. After cresting the hill on approach to the intersection, Mr Peak applied the brakes, experiencing a partial lockup. The B-double combination started sliding and rotated rapidly in a clockwise direction causing it to enter the eastbound lane into the oncoming path of the Honda Civic. The rear of trailer B impacted the gravel bank off the northern side of the highway causing the combination to fold in on itself. During this part of the crash sequence, the rear left side of the prime mover slid off the roadway and its rear left drive wheels contacted the oncoming Honda Civic, pushing it off the roadway and into the northern bank. Mr Putra was crushed by the impact and died at the scene. His partner survived. Mr Peak was not physically injured but soon went into shock, requiring transfer to hospital.
34. There was no dashcam in either vehicle and no CCTV camera coverage of collision location.
35. Two local police officers witnessed part of the crash sequence but not the impact. They were patrolling McGlews Road approaching the intersection. Their attention was caught by the B-double combination's clearance lights moving in an unusual way on the highway. This was captured on the police vehicle's dashcam. The footage shows the prime mover and the first trailer starting to rotate clockwise as it approaches the intersection, progressively rotating and starting to fold in on itself as the combination slides through the intersection. The brake lights were activated.
36. Mr Putra's partner told police he was driving at around 70-80km/hr because of the heavy rain. She recalled seeing the truck:
- ...far away..it was already crooked..the truck was sliding and the trailer was across the road spinning around towards us. I saw Arie slowed the car down and pulled over to the left of our lane. After about three seconds the truck was sliding towards us and the back left side of the trailer hit our car and pushed us off the road.*
37. There is no dispute Mr Putra was driving appropriately for the conditions immediately prior to the collision. He was left with no time or opportunity to take more evasive action to avoid the collision. Mechanical inspection of the Honda Civic identified no defects that could have contributed to the collision.

Mr Peak's version of events

38. The local police officers went immediately to the scene to render assistance. Their interaction with Mr Peak was captured on body worn camera.
39. Counsel Assisting played the footage for Mr Peak at the inquest. He said he heard himself say "*It wasn't even on fucking cruise*". He explained he volunteered this information because he assumed the police officer was probably thinking he was just sitting on cruise.

40. Parts of the audio are difficult to hear. I have listened to it multiple times and hear Mr Peak say the following when the police officer asked him what happened:

I just come round that bend it just fuckin' slid on me like totally out of control man thought fuck I'm gonna die man...I don't even know what happened, I don't know what happened man.. I was on that bend and I'm fuckin'..wasn't on the cruise and fuckin' next minute..I totally, I totally, I totally turned round went backwards man, I don't know what happened.

41. He did not see the Honda Civic.

42. The paramedics' report of their attendance on Mr Peak document:

Pt unsure of circumstances around accident, however stated driving approx. 90km/hr. Road conditions wet with heavy rain.

43. The Stanthorpe Hospital records document Mr Peak's distress knowing a young person died in the collision. He could not understand what happened to lose control of the B-double combination.

44. Mr Peak subsequently exercised his legal right not to answer certain questions about the collision when participating in an electronic record of interview with police. He gave oral evidence at the inquest under a direction given pursuant to section 39 of the Coroners Act.

45. Mr Peak tested negative for alcohol and drugs.

Was the trailers' EBS connected to the prime mover and powered at the time of the collision?

46. The forensic crash investigator confirmed seeing the suzi cord for the trailers' EBS was connected to the prime mover when he inspected the B-double combination at the crash site. The cord had ruptured due to over-extension during the jack-knifing. There is no evidence Mr Peak was driving without this physical connection between the prime mover and the trailers that night.

47. The forensic crash investigation identified concern that the trailers' EBS did not operate to detect the wheel lock up and keep the B-double combination stable. Otherwise, the prime mover and the trailers were assessed to be in satisfactory mechanical condition, and the prime mover's ABS recorded no active fault codes, indicating it was operating correctly.

48. The concern about the trailers' EBS arose because:

- (a) the B-double combination jack-knifed
- (b) inspection of the prime mover by a technician from a local IVECO franchise identified there was no ignition or battery supply from its ABS connector.

- (c) data downloaded from the WABCO Electronic Control Units did not record the jack-knife event or fault codes close to the download odometer reading; and
 - (d) when the damaged trailer EBS connection cord was repeatedly reconnected to the prime mover, the trailer ABS warning light was illuminated in the lower left corner of the dashboard and disappeared again when the cord was disconnected indicating the warning light was functioning correctly when tested.
49. In a statement provided in late November 2025, the technician who inspected the prime mover confirmed the main fuses tested okay and recalled earth testing at the ABS connector was okay. He did not inspect the trailers.
50. The technician explained how the prime mover's reducer module has inbuilt circuit protection which generally indicates the use of a circuit breaker or similar electronic controlled circuits inside the module that will cut the power supply to the ABS connector for the trailers in the event a short circuit or circuit overload is detected. This event could be caused by damaged wiring to or a faulty component on the trailers. He advised that sometimes a short or overloaded circuit can be an intermittent issue and hard to detect, leaving only the result of a blown fuse or in rare cases failed circuit protection stuck in an off (no output) state or failed module. If the prime mover was in a state of not supplying the trailer EBS with ignition or battery immediately prior to the collision, the trailer EBS would not have been operating. While in his opinion it was unlikely, the technician could not exclude the possibility that the condition of no ignition or battery supply to the trailer EBS connector resulted from collision damage.
51. The inquest heard from Steve Cuzzupe, Engineering Manager of Transport Engineering Solutions which supplies the WABCO Smart Braking System in Australia. He helped the forensic crash investigation by providing general information about how the system operated and facilitated a download from the trailers' EBS.
52. The forensic crash investigator did not seek a formal report or statement from Mr Cuzzupe documenting his advice or interpretation of the download data. At the inquest Mr Cuzzupe explained that the system records vehicle performance data. It does not perform a 'black box recording' function to identify specific events that could be linked to the crash sequence.
53. Mr Cuzzupe's oral evidence explained the function and limitations of the WABCO Smart Braking System in the conditions immediately preceding the collision:
- (a) the system did not incorporate a high speed anti-jack-knifing function and could not record that type of event.
 - (b) if the system detected wheel lock up and loss of traction, it would operate to reduce braking force get the wheels to turn again, maximise traction

with the road surface, reapply the brakes and keep the B-double combination stable in linear alignment. In doing so it would prevent the trailers from pushing past the decelerating prime mover. He said it is very rare for a heavy vehicle combination to jack-knife when the ABS is working properly and has never heard of it happening.

- (c) if the system was not connected to the prime mover at all, or there was a break in power supply to it, the system would switch off. It could not record any data. If the trailers' EBS was not plugged in, there would be no warnings because the prime mover would not know it was pulling the trailers. If it was plugged in and detected an issue with the power supply, the system would alert the driver by activating the trailer EBS warning light.

54. The download data for both trailers last records a diagnostic event several hundred kilometres prior to the download odometer reading recorded by the WABCO system. Mr Cuzzupe explained that if the system has been powered consistently, its odometer reading should match the hubbo on the trailer. A discrepancy indicates it was not. The forensic crash investigation did not document the trailers' hubbo odometer readings so this correlation could not be assessed.

55. The inquest was also informed by evidence from NVHR Chief Engineer, Les Bruzsa. Mr Bruzsa's qualifications and expertise in heavy vehicle performance and heavy vehicle technology are well recognised both in Australia and internationally. He told the inquest that EBS are extremely sophisticated and can significantly reduce the risk of potential rollovers or jack-knifing. In his professional opinion, in circumstances where there was water on the road (which was otherwise in good condition) and after coming down a slight hill the truck driver touched the brakes to reduce speed, if operating properly, the trailers' EBS should have slowed the heavy vehicle combination in a straight line.

56. Mr Peak and his employer, Brian Murphy, Director of A Black Comet Pty Ltd, believe the incident would have occurred regardless of whether the trailers' EBS was operating. I accept and prefer the opinions of the two industry experts on this issue that had the trailers' EBS operated as intended when the prime mover went into lockup, it would more likely than not have slowed the B-double combination in a straight line. That this did not happen, coupled with the absence of recorded data from the WABCO Smart Braking System proximate to the collision, supports a finding that although physically connected to the prime mover's supply plug, the trailers' EBS was not receiving power supply immediately prior to the incident.

Was Mr Peak aware there was an issue with the trailers' EBS prior to the collision?

57. Mr Cuzzupe explained that the trailer ABS warning light on the dashboard alerts the truck driver to the existence of an active fault with the system. It does not identify a specific fault code. This warning light could signify a

variety of faults, not just a power supply issue. The onus is then on the truck driver to determine whether to continue driving the heavy vehicle combination, try to troubleshoot the fault themselves or take the vehicles to the workshop where service technicians can diagnose the specific fault using program software.

58. With reference to his knowledge of warning light systems in other makes of prime mover, Mr Peak's evidence was that the IVECO prime mover *would have had* a two-stage warning light system using an amber light to signal a non-critical issue and a red light to signal a critical one. He also described an audible alarm or buzzer. Mr Murphy confirmed this. However, Mr Peak acknowledged never having seen this two-step warning process in this make of truck.
59. The relevant IVECO Powerstar operator manual was not evidence to test their evidence.
60. Neither of the industry experts were familiar with this model IVECO.
61. Mr Bruzsa agreed with the proposition put to him by Mr Peak's legal representative that across makes of prime mover there can be different colours for particular warnings, and some can be audible. While he has seen manufacturers' systems incorporate a warning light on the dash and another warning in the console for the same issue, he could not be certain this was the case for the IVECO prime mover.
62. Mr Peak's evidence was that prior to leaving the Victorian depot he checked the dash for any warning lights. He explained that all the warning lights appear for about 10 seconds when the engine was turned on, then generally clear. If one remains on, it indicates an issue. He said nothing was a problem when he left the depot. He described the prime mover as *a pretty old truck, it had done a lots ks*. He did not recall anything major come up during his journey to Queensland and did not report anything to Datspares Transport during the job.
63. When shown a photograph of the prime mover's dash with the trailer ABS warning light illuminated, Mr Peak agreed that light *could* have been on that night. His evidence is it was *only a warning light* and he would have reported it when he next stopped but the collision occurred.
64. The police body worn camera footage shows Mr Peak sitting in the driver's seat with the engine running when the first response officer first approached the truck. The officer told Mr Peak to shut off the engine. Unfortunately the angle of the footage does not capture the vehicle's dashboard or show whether the trailer ABS warning light was on at that time.
65. Mr Peak's oral evidence supports a finding he was likely to have been aware the trailer ABS warning light was on at some stage during his journey. However, there is insufficient evidence to determine when and for how long the warning light was on before the collision. On the available evidence it is

not possible to identify at what point in the journey or how the trailer EBS came to be without power supply.

Was Mr Peak's manner of driving appropriate for the conditions immediately prior to the collision?

66. This question requires consideration of his decision to drive in the inclement weather that night, knowing the trailer ABS warning light was on, and having regard to the combination's GCM and his speed immediately prior to applying the brakes.

Should Mr Peak have been driving in the weather conditions per se?

67. Mr Peak recalls it was a *pretty rugged night* when he commenced his return journey from Brisbane. With his decades of truck driving experience, he was comfortable driving in the inclement weather. He had driven this stretch of highway previously so it was not an unfamiliar route. He was not the only heavy vehicle combination on the highway at that time. One of the first response police officers told the inquest he was not surprised to see heavy vehicle traffic on the New England Highway in the prevailing weather conditions that night.

68. I find it was reasonable for Mr Peak to be driving the B-double combination in the weather conditions that night. However, his decision to continue driving in very heavy rain knowing the trailer ABS warning light was on at some stage is more nuanced.

Should Mr Peak have continued driving in the heavy rain knowing the trailer ABS warning light was on at some stage?

69. When asked whether there was anything particular he noticed about how the B-double combination was handling after leaving Acacia Ridge that night, Mr Peak said:

it felt fine...Everything – everything felt pretty roadworthy to my knowledge, you know, Within reason – within reason, it felt pretty good. Yeah.

70. He told the inquest that if the trailer ABS warning light was on it generally meant that the *ABS is playing up and could just be a faulty sensor which they are a lot of the time*. He told the inquest:

I think a lot of it comes down to rain, that's probably what's playing up that night, just heavy rain, I think the rain plays up a lot of them...Water gets into the sensors and, yeah, sort of mucks it up and gives a false reading.

71. Mr Peak's evidence is not inconsistent with that of Mr Cuzzupe. In Mr Cuzzupe's many years of experience with heavy vehicle EBS, the most common fault triggering the warning light is when a wheel sensor comes out of adjustment. Mr Bruzsa told the inquest that while the ABS warning light may indicate a power supply issue, operational faults could not be ruled out.

72. The industry experts' evidence gives important context to Mr Peak's evidence about what significance the warning light held for him. He did not identify it as flagging a major issue needing immediate attention. The crux of Mr Peak's decision to continue driving while the warning light was on that night is reflected in his response to Counsel Assisting who asked if he considered that was an issue when he was carrying pallets of sugar and aerosols on two trailers on a rainy night:

Well, ABS is only an anti-brake skidding as I recall. I mean, not a mechanic, you still got full 100 per cent brakes. The brakes still work exactly the same.

73. Mr Bruzsa confirmed the vehicle's conventional braking system will still be working if the ABS system is not operational on the trailers, just without the additional benefits provided by ABS/EBS under difficult circumstances that cannot be controlled in the same way.

74. Mr Peak had been driving heavy vehicle combinations without ABS for about 15 years before he first drove one with this technology. During cross-examination by DTMR's legal representative, he spoke about having to drive differently with EBS because of its autonomous braking, how much truck drivers hate ABS/EBS and expressed a view that ABS/EBS shouldn't exist in Australia because the technology comes from Europe where it snows and rains whereas *Australia is the driest (sic) continent on earth*.

75. Mr Bruzsa acknowledged that traditionally with any new technology there is some opposition from drivers and spoke about the NHVR's efforts to educate and promote the significant benefits of ABS/EBS technologies to the industry given resistance from some industry players.

76. Mr Peak's evidence indicates confidence in his decades of truck driving experience and the vehicle's conventional braking system without the extra safety precaution of the trailer's EBS, regardless of what issue the trailer ABS warning light may have signified.

77. The illuminated trailer ABS warning light signalled an active system fault but did not identify what it was. The vehicle's conventional braking system still worked meaning Mr Peak could still drive the B-double combination but his ability to control it was not augmented by the extra protection of trailer EBS on a wet road surface. Given the very heavy rain, it would have been prudent for Mr Peak to stop, check the EBS connection and troubleshoot the fault but he did not consider there was an EBS issue requiring prompt attention. The heavy rain was not conducive to stopping. He was very comfortable relying on his driving experience and the vehicle's conventional braking system in any event. Tragically for Mr Putra, this confidence was misplaced.

Was Mr Peak driving too fast for the conditions?

78. Mr Peak told the inquest he was driving *on the foot* (meaning off cruise control) so he could vary his speed to the road conditions. This is consistent with what he can be heard telling the police officer at the crash scene. He explained he would '*back off and drive to the road conditions*' when driving in the rain, meaning he would reduce his speed to 90-95km/hr and then adjust accordingly.
79. He told the inquest the prime mover was speed-limited enabling him to sit on or around a maximum 103km/hr.
80. The forensic crash investigator initially estimated the prime mover was travelling at 100-108km/hr prior to the collision. He calculated this range with reference to information obtained from a Garmin navigation system found in the prime mover cabin (which calculated an average speed of 100km/hr over the final 800 metres) and data downloaded from the vehicle's Engine Control Module (ECM) which produced Speed Deceleration Reports. These reports did not record a date or time for any recorded driver input, meaning they required correlation with other information including knowledge of required engine performance for the terrain approaching the collision location and the dashcam footage from the police vehicle.
81. With this correlation, the forensic crash investigator identified the prime mover's performance for 60 seconds leading up to the collision. The data recorded engine load placed on the prime mover, consistent with going up a hill and then loss of engine load consistent with it going down the hill leading up to the brake application. The Speed Deceleration Report records the prime mover's speed increased from 103km/hr to 108km/hr with no throttle application about four seconds before the brake application, consistent with Mr Peak's path of approach to the intersection. The forensic crash investigator calculated the heavy vehicle combination was either at the bottom of the hill or at the flat section approaching the intersection at this point.
82. The recorded period of brake application (4-6 seconds) corresponds with the time frame in which brake lights are visible when the B-double combination is seen entering, rotating and sliding through the intersection, as captured on the police dashcam footage. However, the rate of travel evident in this footage does not correspond with the recorded speed of the prime mover's drive wheels from 93km/hr to 20km/hr during this 4-6 second interval during which dashcam footage indicates the drive wheels were experiencing partial lock up.
83. The forensic crash investigator subsequently acknowledged the software used to obtain the ECM download was a fleet monitoring system. As such, without validation from another source, he would not rely on the Speed Deceleration Report data for law enforcement purposes.

84. Mr Peak denied he was exceeding the speed limit immediately prior to the collision, maintaining that at most he was travelling at or around the maximum 103km/h. He said that conservatively he would have been travelling between 90-100km/hr but agreed he had been travelling closer to the maximum speed of 103km/hr.

85. When asked to step through his recollection of what happened, he said:

I only got – non-digital speedo, I just got an analogue speedo, probably noticed it creep up a bit, so I just sort of feathered the brake a bit, wiped off a bit of speed. Probably – um – started taking the bend and really thought nothing of it and then it just sort of, in a heartbeat, yeah, it was sort of – yeah. Well obviously, yeah, it was all sort of over..

And later:

..it's a bit of a crest in the hill, but – yeah. It's no – no big hill. Yeah. Probably got the truck – probably got a little bit faster. Yeah. Just got analogue gauge, as soon as I sort of saw that wiped of a bit, wiped off sort of legal – legal speed – you know. And um – you're – so it's the right-hand bend. Yeah. I mean it's no big deal. So I've been driving a good 20 years, wasn't really phased by it at all. I don't really know what happened to be honest.

86. On Mr Peak's evidence, the heavy rain was not a *big deal* for him, and he felt comfortable driving that night. He agreed he had been travelling closer to 103km/hr. While the precise speed at which he was travelling before he applied the brakes remains undetermined, he clearly recognised the need to slow the B-double combination down, correcting for excess speed gained as he descended the hill into the sweeping right hand bend approaching the intersection. What followed demonstrates speed was a contributory factor given the adverse weather conditions that night.

Did Mr Peak's manner of driving take account of the B-double's combination's GCM and load distribution?

87. Based on information the forensic crash investigator obtained from the load sheets and Datspares Transport about B-double's combination's unladen and laden weights, the investigator estimated it was operating with a GCM of 14.5 tonnes or 23% less than its maximum GCM. His calculation is set out in an email exchange with the business on 11 January 2022 in which he sought confirmation that *"with the listed load at the time being about 19.88 tonne then the GCM would be about 47.88 tonne with the maximum general mass limit for the vehicle being 62.5 tonne."* Mr Murphy's daughter indicated that would be right.

88. The forensic crash investigator identified this may have contributed to it being 'over braked' and more prone to wheel lock up under brake application. The heavier the load, the more traction. The lighter the load, the more careful the driver needs to be when braking.

89. Mr Murphy told the inquest the combination:

only had 20 tonne, 22 tonne on the whole double set – uh – she wasn't even close to being fully loaded. Um – now, that is a huge disadvantage when you have really bad weather. The more weight you have in it, in really bad weather – the better – um – and that mightn't have helped things either.

Under cross-examination by Mr Peak's legal representative, Mr Murphy explained his estimate of 20 tonnes was based on the weight of the bulk sugar Mr Peak was carrying, because Mr Murphy had to deliver it to customers following the collision. He acknowledged there were other items onboard.

90. Mr Peak disagreed with the investigator's GCM estimate. He told the inquest *we were always heavy at company coming out of Brisbane* and remembered saying *I was up near the 60 tonne cause I sort of had to – had to – you know, to tell the forkie to spread it a bit – a bit carefully cause you've got all your axle groups as well.* He was certain he was way over 48 tonne and the combination *should have really stayed on the road.* Nonetheless, he identified 48 tonnes was *still pretty heavy.*

91. Without evidence about how the load was distributed across the trailers, I cannot make a properly informed finding about whether Mr Peak was driving appropriately for the GCM and the load distribution in the weather conditions that night.

Did road surface drainage issues and water pooling play a role in the collision?

92. When the forensic crash investigator arrived at the scene, he observed areas of water pooling in the worn travel paths in each lane, at least probably boot sole deep on the highway which he considered may have impacted the heavy vehicle combination's traction.

93. The area had received approximately 34mm of rain on the day leading up to the collision. The forensic crash investigator advised it was deemed not safe for police to conduct non-ABS (sliding) friction testing because of water over the road surface.

94. The investigator's later inspection of the dry road surface during daylight identified the crossfall of the road in the westbound approach was nearly flat, and even during light rain there was some water pooling in the westbound side of the road.

95. The DTMR crash site assessment identified that previous works at the site impacted the surface drainage at the intersection because it left a difference between the superelevation in the centre of the road and the road shoulder, resulting in limited crossfall and grade for surface drainage. The surface

drainage did not meet the required Austroads drainage standard for roads with a 100km/hr speed limit.

96. Aquaplaning assessment identified two sections of kerb that had potentially experienced ponding due to flat grades. In both locations, rutting in the wheel path was allowing the water to collect.

97. In early 2026, DTMR resurfaced the section of road from approximately 100 metres east of the intersection with Caves Road to approximately 60 metres west of the intersection with McGlew Street.

98. One of the local first response police officers told the inquest he was not aware of concerns or issues with water pooling on the road at the intersection prior to the collision. This is reflected in the reported crash history for the intersection.

99. DTMR submits the inadequate drainage had no impact or influence on the collision because the heavy vehicle combination was already out of control some 300 to 400 metres away from the area concerned.

100. As discussed in paragraph 81 above, the forensic crash investigator placed the B-double combination either at the bottom of the hill or at the flat section approaching the intersection in the four seconds before Mr Peak applied the brakes.

101. While Mr Peak could not recall the whole event, he said:

I wouldn't say I lost traction straight away. I remember going through the sweeper and it was, yeah, raining pretty hard, and I didn't really think anything of it. And I wouldn't say it just lost straight – I wouldn't – I wouldn't, yeah. In my recollection of it, I don't reckon it just fell off the road straight away..It sort of, sort of happened, like, I mean, happened fast, but it wasn't like you just tapped the brakes and it was just, whoosh, it was, no.

102. The police dashcam footage clearly shows the prime mover starting to rotate clockwise before entering the intersection, indicating the loss of control occurred an unknown but not significant distance to the east of the intersection. While I cannot be satisfied there was water pooling on the road where the B-double combination first lost traction, the water pooling in locations observed by the forensic crash investigator certainly did not help the situation.

103. While it is reasonable to expect Mr Peak adjust his driving to the very heavy rain conditions, he could not have anticipated the road surface drainage issues in the vicinity of the intersection.

Had there been an issue with the trailers' EBS prior to this job?

104. Top Start Hire Pty Ltd provided documentary confirmation that the EBS connections to both trailers were operational when they were hired to Datspares Transport.
105. Mr Murphy told the inquest they had to send one of the trailers back to Top Start within a couple of weeks of receiving it because it was *setting off the alarms* in the truck and there was an issue with the mezzanine floor mechanism. He said he was never told what the issue was, and it did not happen again. Records provided by Top Start Trailer Hire did not contain information about this issue.
106. The evidence of Mr Peak, Mr Murphy and his daughter who worked in the business is that drivers could report an issue by phone, text message, in person or on a sheet of paper attached to their clipboard or manifest. That information was passed on to Mr Murphy who oversaw the maintenance, or to the mechanic closest to the driver's location.
107. Mr Murphy's daughter dealt regularly with the drivers. Amongst many other things she filed the paperwork. The business maintained paper records and a physical folder for each vehicle. It did not use an electronic management system for maintenance and repairs. She was not aware of any maintenance issues with the prime mover or the trailers prior to the collision. She described Mr Peak as a very reliable and skilled driver. She did not recall him reporting any issues relating to the prime mover or trailers. Mr Murphy did not recall there being any issues with the EBS connection between the prime mover and the trailers.
108. The forensic crash investigator requested maintenance records from Datspares Transport for the heavy vehicle combination. Ms Murphy recalled scanning a lot of physical documents because *it took forever* and emailing them to the investigator as a compressed file. The investigator has no record of receiving this email or its attachment, and did not follow up with the business about this missing information before submitting the final crash investigation report. The investigator explained this was because the mechanical inspections did not raise any red flags about maintenance or servicing issues. Subsequent efforts to obtain the records were unsuccessful. Ms Murphy said she could not locate her original email due to email storage limitations, the scanned documents or the compressed file, and said the physical maintenance records were lost in a move.
109. The evidence indicates Datspares Transport was not operating a sophisticated or contemporary maintenance and repair information management system. Mr Peak described it as a *very casual sort of setup*. Mr Murphy's confident assertions aside, Ms Murphy presented as a conscientious young woman whose account of the time it took to scan the contents of the vehicle folders I accept to be truthful. I accept that records for the prime mover and the trailers existed. I would have been better

assisted had they been available to the forensic crash investigation and inquest.

110. The WABCO download data for each trailer includes a section recording diagnostic events. None relating to a break in power supply were identified during Mr Cuzzupe's oral evidence. Without knowing whether the odometer download reading matches the total distance travelled by each trailer, I cannot be satisfied this means there were no previous issues with power supply to the trailers.

Findings required by s. 45

Identity of the deceased – Arie Hirdansyah Putra

How he died –

Arie Hirdansyah Putra died from traumatic asphyxiation when the small car he was driving was crushed by a B-double combination which jack-knifed because it lost traction with road after the truck driver applied the brakes to correct excess speed gained as the vehicle descended a gentle hill in very heavy rain. There was water pooling on the road due to road surface drainage issues in the vicinity. Although the trailers were fitted with an electronic braking system which was physically connected to the prime mover, it did not operate to slow the vehicle to a stop in linear alignment. This is because the electronic braking system was not powered. It is likely the truck driver knew the trailer ABS warning light was on, signalling the existence of an active system fault, but in his truck driving experience did not consider it was an issue needing prompt attention. Had the trailers' EBS been operating properly, it would have significantly reduced the risk of jack-knifing. Mr Putra was left with no time or opportunity to take more evasive action to avoid the collision.

Place of death –

New England Highway STANTHORPE QLD
4380 AUSTRALIA

Date of death–

22/03/2021

Cause of death –

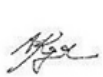
1(a) Traumatic asphyxia
1(b) Motor vehicle collision (driver)

Comments and recommendations

111. Mr Bruzsa explained the ABS/EBS requirements of the national heavy vehicle regulatory framework as they applied to the B-double combination. Both the prime mover and the trailers were compliant with relevant requirements to *fit* ABS/EBS for that specific combination.
112. The Vehicle Standards Guide 25 requires that the ABS/EBS plug be connected. Appendix 1 of Australian Design Rule 35/03 requires there to be an active power supply between the prime mover and the trailers, and any break in the supply of electricity to, and any electrical failure of the ABS/EBS must be signalled to the driver by an appropriately labelled and located optical warning signal. The prime mover's trailer ABS warning light function complied with this requirement.
113. Mr Peak's assessment of what activation of that warning light was telling him that night, and his response to it, lies at the heart of the crash sequence resulting in Mr Putra's death.
114. Mr Bruzsa told the inquest the NHVR is currently working on strategies to promote and support more active use by the industry of technology to improve on-road vehicle performance and safety. He spoke in very general terms of work around better informing drivers of the operational status of the systems fitted to their vehicles, noting there are conflicting views about what is the most effective alarm system given the number and variety of safety systems fitted to a heavy vehicle. He agreed that an optical warning light system which clearly differentiated between non-critical and critical faults could be a solution.
115. The inquest explored whether trailer ABS/EBS should be augmented by a back-up power source in the event of a break in power supply. This is not a current regulatory requirement.
116. Mr Cuzzupe spoke about alternative power sources in use in Europe, for example, *if the plug connection loses power for some reason, they can then draw power from the stop load system to power it*. Mr Bruzsa advised that while there has been work happening on back-up power sources, he is not aware of current proposals under consideration.
117. Mr Bruzsa provided valuable context about the very involved and lengthy process by which changes are made to elements of the national heavy vehicle regulatory framework. It is not simple or swift. It requires cost benefit analysis and extensive industry consultation. The technology is very sophisticated and under continual development. There are features of the Australian industry that complicate adoption of European technologies, such as the variety and number of vehicles used in combination by Australian transport companies and the diverse conditions in which they operate across the country.

118. Being mindful of this complexity, I urge the Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts to examine opportunities to strengthen the national heavy vehicle regulatory framework to support drivers to identify and respond to critical safety system faults and allow for the use of a back-up power source in the event of a break in power supply to or any electrical failure of a trailer ABS/EBS system.

I close the inquest.



Ainslie Kirkegaard
Coroner
BRISBANE

6 August 2026