FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2525/07

Inquest into the Death of ANDREW CLOUGH

Delivered On:	
Delivered At:	Melbourne
Hearing Dates:	10 December, 2008 and 11 December, 2008
Findings of:	JOHN OLLE
Representation:	Mr M. Cvjeticanin, Counsel for family
	Ms S. Hinchey, Counsel for VicRoads
	Mr D. Masel, Counsel for Mornington Peninsula Shire Council
Place of death:	Alfred Hospital, Commercial Road, Prahran 3181

SCAU: Acting Sergeant R. Antolini, Coroner's Assistant

FORM 37

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FINDING INTO DEATH WITH INQUEST

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Court reference: 2525/07

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname:	CLOUGH
First name:	ANDREW
Address:	52 Tubbarubba Road, Merricks North 3926

AND an inquest having been held before Coroner Drake in relation to this death on 10 December, 2008 and 11 December, 2008
at Southbank
find that the identity of the deceased was ANDREW CLOUGH
and death occurred on 4th July, 2007

at Alfred Hospital, Commercial Road, Prahran 3181

from
1a. MULTIPLE INJURIES (MOTOR VEHICLE IMPACT - DRIVER)

in the following circumstances:

1. Andrew Clough was aged 37 years at the time of his death. He lived at 52 Tubbarubba Road, Merricks North, with his wife, Michelle, and their 2 year old son, James. The family had moved to this address approximately six weeks previously.

2. Mr Clough was employed as a chemical engineer for ModuSpec in Melbourne.

3. He was described:

> "as an extremely cautious and careful driver, who did not speed and was considered to be a very safe driver by his family and friends."[1]

[1] Statement S/C Harney p.11

4. At approximately 7.00am on the 4th July, 2007, Mr Clough left home for work. It was dark, the roads were wet and it was raining.

5. Travelling east on Myers Road, Merricks North, Mr Clough approached the intersection of Balnarring Road ('the intersection'). His vehicle entered the intersection without slowing, braking or taking evasive action, colliding with a vehicle travelling in a northerly direction along Balnarring Road.

6. Mr Clough was unfamiliar with the intersection.

7. It is estimated Mr Clough's vehicle was travelling at approximately 90kph at the point of impact. Mr Clough sustained multiple injuries. He was airlifted to the Alfred Hospital with life threatening injuries and died later that morning.

About an Inquest

8. The Coroners Court is different from other courts. It is inquisitorial rather than adversarial. In other words, an inquest is not a trial, with a prosecutor and a defendant, but an enquiry that seeks to find the truth about a person's death - to establish what happened, rather than who is to blame. This gives Coroners more freedom but less power. They are more flexible in the evidence they accept, but they cannot punish. Instead, they make recommendations, if appropriate, that may have help avoid similar deaths.

9. Coroners consider all the evidence and material that comes before them. Not every issue make its way to the finding but everything has been weighed up and analysed.

Issues for the Inquest

10. Pursuant to the 1985 legislation, under which the inquest was conducted, a coroner investigating death must find:

1. Section 19 Coroners Act 1985:

- the identity of the person has died;
- the cause of death;
- how the death occurred.

11. The medical cause of death and the identity of Andrew Clough are not an issue. They are recorded on the title on this finding. The focus is on the circumstances in which he died, specifically:

1) whether appropriate warning of a Stop sign was provided to Mr Clough?

The facts found by me:

- Mr Clough was unfamiliar with the intersection;
- It was dark, raining and visibility was poor;
- The full impact of the tunnel effect posed by overhanging vegetation on Myers Road, is difficult to ascertain;
- Neither driver was aware of the other vehicle until impact;
- Road markings and stop signage applicable to Mr Clough were deficient:
- Headlights of each vehicle failed to forewarn either driver.

VicRoads

12. Pursuant to Section 49 of the Road Management Act 2004, VicRoads was responsible for inspection and maintenance of the intersection.

13. In particular, VicRoads acknowledged responsibility for any signs controlling traffic movement in and out of the intersection and any advance direction signs, advance warning signs directly related to the intersection.[2]

14. Pursuant to the Road Management Plan, Balnarring Road was classified as a Category 3 road. It was inspected on a weekly basis during the day and once every six months at night.

15. Mr Thomas explained VicRoads was responsible for replacing damaged signage and markings and was required to ensure signage and markings complied with relevant standards.[3]

16. Niall McDonagh, Team Leader - Traffic & Road Safety, Mornington Peninsula Shire[4] assessed the intersection following the collision. He reported:

"Western Approach

- Installation of crossroad signage on minor road (road required to yield) is incorrect and provides false information to the motorist.

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2 VicRoads Submission p.2
3 Thomas T-73; VicRoads Submission p.3
4 Letter to Sergeant Stockdale dated 11 July 2007 set out results of an inspection of the intersection on the 10 July 2007.

- Advance warning stop sign ahead signage is not located within motorists sight lines. It seems the sign has been knocked over in the past, and not been reinstated correctly (currently leaning against a tree)
- The existing awareness bars on the approach to the intersection have not been installed to the correct standard.
- All signage has lost its reflectivity."

17. Mr McDonagh set out deficiencies identified in respect to the Eastern Approach, Southern Approach and Northern Approach. He explained:

> "It is believed that this intersection was not operating at an appropriate standard to provide advance warning for approaching motorists."

18. Mr McDonagh exhorted the council to urgently commit to:

> ".... ensuring that the intersection signage is corrected and improved, as discussed at our on-site meeting..... Also, Council will ensure that the over hanging vegetation on the eastern approach is trimmed.
>
> In addition, the current crash statistics of this intersection will allow it to be ranked as a blackspot location and therefore has the ability to attract funding for more significant improvements works, such as approach splitter islands on Myers Rd. VicRoads have given the commitment to further investigate the possibility of funding through this years black spot program."

19. The VicRoads contractor was not called to give evidence. Mr Thomas deposed that VicRoads were satisfied that its contractors met contractual obligations. I note with concern that following a serious collision at the intersection in November, 2006, VicRoads did not carry out an assessment of the intersection.

20. Mr Thomas acknowledged that the contractor's records relating to the inspection, made no reference to Myers Road. The inspection reports only mentioned Balnarring Road and its approaches. Questioned on this point in respect to the last occasion a night time inspection was conducted, Mr Thomas stated that only deficiencies would be reported. Examination of the report reveals that the inspectors noted:

> "Balnarring Road, 30/1/2007, 1035pm inbound. Line marking good, RPMs good, 10.5"[5]

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[5] T-92; Ex 7

21. Contrary to the belief of Mr Thomas, in fact the inspectors noted compliance, not deficits in respect to Balnarring Road. Once more, no reference was made to Myers Road.

22. In addition, a report following an inspection of the intersection conducted in October, 2006 following a complaint from a member of the public referred only to the Balnarring Road approaches.[6]

23. Of more significant concern, the report of VicRoads following the death of Mr Clough states:

> "As Mornington Peninsula Shire Council is responsible for the management of Myers Road, they have made arrangements to replace the existing stop signs, and advance stop signs on Myers Road, with larger signs in a gateway treatment on both approaches to Balnarring Road. As part of these works, Council will also be removing the existing cross road intersection warning signs on Myers Road."[7]

24. Mr Thomas clearly understood the responsibility of VicRoads in respect to the intersection. Less clear is whether VicRoads inspectors equally understood.

25. There is no evidence before me to explain the failure of VicRoads to fulfil its statutory obligations identifying the deficiencies referred to in Mr McDonagh's report.

26. I consider the overhanging foliage evident on the western approach should have highlighted the need to correct the deficiencies, identified by Mr McDonagh. The only plausible reason the deficiencies were neither acknowledged nor rectified, is that the inspection process did not include Myers Road approaches.

27. I accept the submission of the family:

> "In all of the VicRoads routine safety/hazard inspection records there is not a single reference to any inspection of any kind of the Myers Road approach to Balnarring Road."[8]

28. According to VicRoads records, prior to the collision the intersection was last inspected on 27 June, 2007; only days prior to the collision. Due to the nature and extent of the identified deficiencies, I do not accept that they occurred after the final inspection.

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6 Ex 2 Thomas statement
7 Ex 4 Thomas statement
8 Family Submission 12 May 2009

29. Further, I consider the deficiencies obvious. They should have been noted in the inspection process and speedily rectified. The danger posed to motorists, travelling east on Myers Road should have been readily apparent.

30. Whether the inspection process included an inspection of the Myers Road western approach to the intersection, or whether it did so but failed to identify the glaring deficiencies cannot be determined on the evidence.

31. Irrespective, the failure to maintain the intersection to meet established standards rests with VicRoads.

The circumstances of the collision

32. VicRoads submit Mr Clough would have observed a vehicle cross the intersection when he was approaching the intersection. On this basis VicRoads submit he should have been aware of the existence of the intersection.

33. Whether or not Mr Clough observed the vehicle travelling ahead of Mr Loft cannot be ascertained. In any event, knowledge of the intersection would not lead to an inference of danger and/or a need to slow or stop.

34. Mr Clough was travelling on a 100 kph zone. If he observed a vehicle cross Myers Road as he approached the intersection, absent warnings, he would have no reasonable basis to perceive danger or a need to stop his vehicle.

- He was travelling in a 100kph zone
- The identified deficiencies in road markings, warning signs and Stop sign reflectivity caused Mr Clough to enter the intersection, unaware that a Stop sign was applicable to him
- Further, a sign indicating to motorists on major roads with a right of way was incorrectly placed on Myers Road. If Mr Clough had seen the sign, he would have believed he had right of way through the intersection.

35. Of note, Mr Clough's headlights were operating.[9] Mr Loft did not observe the headlights of Mr Clough's vehicle:

> "There would not have been a second between when I saw the light and then hitting the car. I did not have time to brake or deviate."[10]

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[9] S/C Harney statement p.5
[10] Statement Loft p.1

36. In all the circumstances, due to the poor visibility, inadequate road markings and signage and potential tunnelling effect, Mr Clough had no reasonable warning that a stop sign was applicable to him.

37. The collision occurred in circumstances in which the vehicles entered the intersection at approximately 90kph. Until virtually the point of impact, the drivers were oblivious to the presence of the other. Mr Thomas accepted this scenario. [11]

38. It follows that neither driver was responsible for the collision.

VicRoads failed to maintain the intersection to appropriate standards

39. It was the responsibility of VicRoads to maintain the signs and markings on Myers Road in a reasonable condition. VicRoads failed to meet its statutory obligation in respect to the intersection.

40. I accept the post collision deficiencies listed by Mr McDonagh were an accurate summation. VicRoads acknowledge:

> "The actions taken since the collision to install new and larger signage and rumble strips on the road, have addressed each of the relevant safety issues that were identified following the fatal collision"[12]

41. Warning strips are designed and installed for good and sensible reasons. They were not standard at the time of the collision. However, they had been painted on the Myers Road approaches to the intersection. They were not of a raised nature and were too close to the intersection to offer any warning to a driver.

42. On the morning of the collision, in the dark, wet conditions, it is unlikely they would have been seen and if so, would have offered no warning. Further, the sole stop sign was situated at the intersection. It offered no advance warning.

43. I accept the evidence of Mr McDougall. The stop sign had no reflectivity and was undersized for a 100kph zone.

44. Further, I accept the evidence of S/C Harney. It is unlikely in all the circumstances that Mr Clough saw the stop sign.

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11 T-83
12 VicRoads Submission p.10

45. Mr Clough was travelling at approximately 90kph in a 100kph zone on a thickly vegetated road. He was unfamiliar with the road. It was dark and raining. It cannot be known whether he saw the vehicle which drove north through the intersection, ahead of Mr Loft.

46. Absent proper warnings, namely reduce speed zone and/or advance Stop sign warning, no reflectivity in the sole Stop sign at the intersection, had he observed the vehicle ahead of Mr Loft, he had no reasonable basis to assume danger or that he did not have right of way.

47. The collision occurred in circumstances in which Mr Clough:

1. Had no reasonable warning that that he was approaching a Stop sign.
2. He was travelling in a 100kph zone.
3. There were no signs warning to reduce speed and/or advance warning Stop sign.
4. An advance warning sign indicated that he was approaching an intersection, falsely indicating he had the right of way.
5. There were no advance warning Stop signs.
6. There were no `rumble strips' at appropriate intervals many hundreds of metres prior to the intersection.
7. The Stop sign at the intersection was inadequate. It was undersized for a 100kph roadway and had no reflectivity.

Opportunity Missed

48. The intersection was dangerous. Unfortunately, an opportunity to assess the intersection in November 2006 was missed. VicRoads made no assessment of the condition of the intersection following the multi-injury collision.

49. Tragically the November, 2006 collision occurred in virtually identical circumstances. Namely a vehicle on Myers Road, entered the intersection apparently oblivious to the danger.

50. Further, if the VicRoads inspection process included the Myers Road approaches, the deficiencies, at the very least some of them, would have been identified. For example, the incorrect Chevron sign and the undersized stop sign. Although there is no evidence when the advance warning Stop sign was moved and placed next to a tree, it is a remarkable coincidence if it occurred after the final inspection on 27 June, 2006. That is less than a week before the collision.

51. VicRoads records indicate that its contracted inspectors had carried out weekly daytime inspections of the intersection for years. Mr Thomas deposed the inspectors and VicRoads overseers are well qualified and experienced.

52. I do not accept that well qualified, experienced inspectors/overseers could have missed the long-standing, glaring deficiencies on the Myers Road western approach to the intersection. Further, the tunnel effect referred to by S/C Harney noted should have raised concern.

53. S/C Harney had difficulty seeing the Stop sign at the intersection in daylight, in the knowledge it was there! [13]

54. VicRoads failed to ensure that the intersection was maintained to appropriate standards.

Tunnelling Effect

55. I am unable to find that a tunnelling effect contributed to the collision. Nonetheless, the nature of the foliage, combined with the obvious tunnelling effect in daylight hours heightened the need to ensure that the intersection had appropriate line markings and signage.

Conclusion

56. At approximately 7.10am on the 4th July, 2007, a motor vehicle driven by Mr Andrew Clough was involved in a collision in which he sustained fatal injuries.

57. One of the reasons the intersection was governed by a Stop sign was lack of vision of vehicles on the respective roads. It was crucial that the Stop sign warnings and road markings were in pristine condition. Drivers approaching the intersection from the west in Myers Road and the south in Balnarring Road could not see each other.

58. I find that Mr Clough was travelling in an easterly direction along Myers Road, Merricks North, at a speed at approximately 90kph. It was raining and dark. Due to the deficiencies set out by Mr McDougall, which I accept are accurate, if Mr Clough was aware of the intersection, he had no reasonable warning that it was governed by a Stop sign applicable to him.

59. Tragically for Mr Clough:

1. his unfamiliarity with the intersection;
2. the dark, wet conditions;
3. the street light which appeared to camouflage for each driver headlight illumination of the other vehicle;

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[13] T-132

4. the deficiencies at the intersection

combined to deny Mr Clough knowledge that he was approaching a Stop sign.

Medical Investigation

60. On the 9th of July, 2007 Dr Malcolm Dodd, Forensic Pathologist performed an autopsy. He found the cause of death to be multiple injuries (Motor Vehicle Impact - Driver)

Finding

61. I find that Andrew Clough died of multiple injuries (motor vehicle impact - driver).

COMMENTS

1. The responsibility borne by VicRoads to inspect and maintain roads and intersections is clear. It's failure to ensure adequate signage and road markings at the intersection was a serious failure.

2. I do not accept VicRoads submission there is:

> "nothing about the physical features of the intersection or the crash statistics associated with it which ought to have alerted VicRoads of a particular need to upgrade existing safety features at this intersection, as opposed to many others across the state"

3. VicRoads were aware of a multi-vehicle collision in November 2006 at the intersection.

4. VicRoads submit that its contractor performed weekly daytime inspections of the intersection and a night time inspection at six months. It submitted:

> "VicRoads records indicate that the contractor fulfilled its obligations under the contract. The contractor did not note any problems with the visibility or physical condition of the signage which control the subject intersection."

5. The intersection was patently deficient in its markings and signage. Many if not all the deficiencies, identified were of long-standing. I accept as accurate Mr McDonagh's list of deficiencies.

6. Mr Thomas acknowledged VicRoads statutory obligation to implement an inspection regime that the assets are in correct and proper order. He explained that VicRoads `would have' carried out inspections of the intersection to ensure it was to an appropriate standard.

7. Mr Thomas and Submissions of VicRoads explained it inherited deficiencies in 2004. I consider the obligation on VicRoads is to maintain intersections which strictly comply with industry, VicRoads and Australian standards.

8. I reject Mr Thomas' justification for VicRoads failure. For VicRoads:

> "to undertake that task would involve ...a diversion of funds from what would be considered higher priority projects."

9. The problem is the process, not the Contractor.

10. The submission of VicRoads that its contractor fulfilled its contractual obligation is both puzzling and disturbing. If inspectors inspected the respective Myers Road approaches to the intersection, the inspection process failed to identify glaring deficiencies at the intersection.

11. The manner in which VicRoads chooses to carry out its statutory obligations is not a matter for me. My concern is that VicRoads in fact, carries out its obligations.

12. At the intersection it failed to do so.

13. VicRoads submit to its credit:

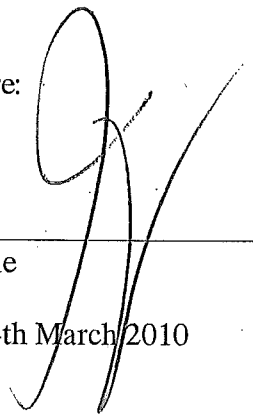
> "The actions taken since the collision to install new and larger signage and rumble strips on the road, have addressed each of the relevant safety issues that were identified following the fatal collision."

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008** I make the following recommendation connected with the death:

1. I recommend that VicRoads conduct an audit of the manner in which it meets its statutory obligations, to ensure deficiencies in road markings and signage at intersections are identified and rectified.

Signature:



John Olle
Coroner
Date: 4th March 2010

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