FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4827/09

Inquest into the Death of CHRISTINE MARY HUMPHREY

Delivered On:	8TH FEBRUARY 2011
Delivered At:	MELBOURNE
Hearing Dates:	8TH FEBRUARY 2011
Findings of:	CORONER K. M. W. PARKINSON
Place of death/Suspected death:	ROYAL MELBOURNE HOSPITAL, GRATTAN STREET, PARKVILLE, VICTORIA 3052
Counsel Assisting:	SENIOR CONSTABLE KING TAYLOR

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4827/09

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: HUMPHREY
First name: CHRISTINE
Address: 11 Morecambe Court, Templestowe, Victoria 3106

AND having held an inquest in relation to this death on 8th February 2011 at Melbourne

find that the identity of the deceased was CHRISTINE MARY HUMPHREY

and death occurred on 10th October, 2009

at The Royal Melbourne Hospital, Grattan Street, Parkville, Victoria 3052

from

1a. CHEST AND ABDOMINAL INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (DRIVER)

In the following circumstances:

1. A summary inquest was conducted into the death of Ms Christine Humphrey on 8 February 2011 at Melbourne. The circumstances of Ms Humphrey's death have been the subject of investigation by Victoria Police. Senior Constable Scott Harris[1] provided a brief to the Coroner setting out the investigations undertaken by police, including statements and documents provided by members of the Victoria Police Major Collision Investigation Unit. I have drawn from these investigations in my findings herein.

2. Ms Christine Humphrey was 45 years of age, born 14 October 1964. She was divorced and the mother of two children, Matthew and Sarah. She resided with her children at 11 Morecambe Court, Templestowe.

[1] A complete description of the investigation undertaken is contained in the police brief prepared for the Coroner by Senior Constable Scott Harris of Boroondara Police Station, 23 June 2010.

3. Ms Humphrey had suffered with depression in 2007, apparently after her marriage break up. She had received support from her General Practitioner, Dr Bendtsen who had prescribed anti-depressant medication and also psychological assistance. She had engaged with a psychologist until August 2008. During this period she was reported to have been consuming alcohol heavily. The evidence is that she had not taken anti-depressant medication for some time.

4. She had reported to Dr Bendtsen at her last consultation on July 17, 2009 that she was managing well and her mood was good. Although she had previously spoken of suicidal intent, there was no suicide note or any other recent indication given to friends or family that Ms Humphrey intended to take her own life. She appeared to family and friends to have been much more settled and happier in recent times. Family and friends did not report that she was apparently depressed or anxious. Her mood on the evening in question is reported as having been buoyant.

5. On 9 October 2009, Ms Humphrey had been at home. During the course of the evening she had held a number of telephone conversations with friends and family. Some noted that it appeared she was alcohol affected, however her demeanour was calm and she appeared to have been of good mood.

6. Sometime in the early hours of 10 October 2009, Ms Humphrey drove her Holden Commodore Sedan registered number VEEEE8 from her home at Templestowe by an unknown route to the intersection of Thompson's Road, Bulleen Road and the Eastern Freeway.

7. At 2.08am the vehicle was observed by witness Mr Steven Lascelles, to enter the Eastern Freeway by the Bulleen Road exit off ramp and travel towards the city. Her vehicle was travelling against the clearly posted 'wrong way go back' signage. Mr Lascelles and several other witnesses observed the vehicle merging from the off ramp into the inner most outbound lane and continuing to travel west, towards the city against oncoming traffic. The vehicle was observed to have been increasing in speed as it left the exit ramp and proceeded onto the freeway. She travelled some distance, approximately 5 kilometres, along the freeway, passing oncoming traffic on a number of occasions.

8. Her vehicle was estimated by police investigators to have been travelling at approximately 127kph when it collided head on with a Toyota Sedan registered number SQK 839 being driven by Mr Wei Chang. Mr Chang was travelling in an easterly direction outbound along the Eastern Freeway, towards his home in Doncaster after finishing work in the city. He was travelling in the lane adjacent to the centre median strip. Mr Chang's vehicle was estimated by police investigators to have been travelling at between 85 and 90kph. The collision occurred on the outbound lanes of the eastern freeway approximately 550 metres east of the Belford Road overpass.

9. The Eastern Freeway at this location is an eight lane divided highway. It has provision for four lanes of traffic in each direction, separated by a grass median. The road runs in a north easterly and a south westerly direction. The lanes of traffic are separated by broken white lines incorporating cats eyes. The outer edges of the carriageway are marked by a solid white fog line. Both carriageways had sealed emergency stopping lanes. The roadway was in good condition and lit by lighting towers. The designated speed limit was 100kph.

10. There is no evidence of emergency braking being undertaken by either vehicle. From the point of impact, both vehicles continued to travel west for approximately 16 metres. The Commodore sedan driven by Ms Humphrey suffered extensive frontal impact damage including intrusion into the driver's cabin. Both vehicles suffered major impact damage. The Toyota sedan driven by Mr Chang was forced rearwards before rolling onto its driver side and roof and coming to rest facing south. Mr Chang died instantly. The circumstances of his death are considered in Inquest Finding 4826 of 2009.

11. Ms Humphreys was transported to the Royal Melbourne Hospital in a critical condition, however died at the hospital on 10 October 2009. An inspection was performed and a report was provided to the Coroner by Dr Melissa Baker, Forensic Pathologist of the Victorian Institute of Forensic Medicine. Dr Baker reported the cause of death as: "Chest and abdominal injuries sustained in a motor vehicle collision (driver)."

12. Toxicology results upon a blood sample taken some 80 minutes after the collision reported that Ms Humphrey had a blood alcohol reading of 0.29g/100mL. I am satisfied that at the time of the collision, Ms Humphrey's blood alcohol level was in excess of 5 times the legal limit for driving a motor vehicle. Dr Maurice O'Dell, Senior Forensic Physician with the Victorian Institute of Forensic Medicine reported upon Ms Humphrey's capacity to drive a motor vehicle. He reported:

> "Her driving skills would have been extremely adversely affected by the effects of alcohol at a BAC of the order of 0.29%. She would have been absolutely incapable of having proper control of a motor vehicle".

13. Victoria police examined the motor vehicle driven by Ms Humphrey and reported that the vehicle was un-roadworthy immediately prior to the collision, however having regard to the circumstances of the collision I am not satisfied that this contributed to the collision or consequently to the death.

14. Mr Chang was driving his motor vehicle home appropriately and in compliance with the road laws. There is no evidence to suggest that he in any way contributed to the collision and I am satisfied that there was no opportunity afforded him to avoid the collision.

15. I have considered whether there was any impediment to the driver being able to identify the freeway access point as being for 'exit' only. The intersection was appropriately signposted by road markings and a no right turn arrow sign. The exit ramp was clearly marked with multiple warning signs. I am satisfied that there would be no impediment to a driver who was unaffected by alcohol observing the nature of the intersection and that the ramp was for exit only.

16. I am not satisfied that Ms Humphrey's conduct on this evening was as a result of a suicidal intent. The evidence of her demeanour earlier in the evening, even when already affected by alcohol, is not consistent with a finding that Ms Humphrey's deliberately and intentionally took her own life and that of another person.

17. The evidence does not satisfy me that factors other than excessive alcohol consumption motivated her behaviour. I am satisfied that Ms Humphrey failed, as a result of her intoxication, to observe the no entry sign posting at the intersection where she entered the exit ramp. I find that as a consequence of impaired judgment she proceeded along the ramp, ignoring the 'wrong way' signposting to the freeway. It is likely that alcohol impaired her capacity to respond in any sensible manner to the situation.

18. I find that the level of alcohol consumed by Ms Humphrey resulted in her being incapable of exercising appropriate judgement or of properly driving or controlling a motor vehicle and that this was compounded by the speed at which she was travelling. As a result she collided with the vehicle driven by Mr Chang and as a result caused her own death and that of Mr Chang.

19. I find that Ms Christine Humphrey died as a result of chest and abdominal injuries sustained in a motor vehicle collision in which she was the driver.

Signature:

Kim M. W. Parkinson
Coroner

8th February, 2011