IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 5974

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of JENNIFER MAY TEAGUE

without holding an inquest:

find that the identity of the deceased was JENNIFER MAY TEAGUE

born 23 September 1948

and the death occurred on 16 December 2016

at the Northern Highway, Runnymeade, Victoria 3558

from:

1 (a) MULTIPLE INJURIES – MOTOR VEHICLE INCIDENT (PASSENGER)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Jennifer May Teague was 68 years of age and living alone in Leongatha at the time of her death. The investigation has indicated that Ms Teague was in receipt of Mental Health Services proximate to her death. However, there is little information about her treatment in the coronial brief and I did not consider it relevant to the investigation into the circumstances of her death.

2. On 15 December 2016, Jennifer spent the night at her brother John's house in Moe, so as she could leave early the next day with him and his wife, Jeanette, to travel to Echuca for a family Christmas gathering.

3. On the morning of 16 December 2016, the Teagues departed for Echuca in John's silver 2011 Volkswagen Jetta sedan [Jetta]. John was driving, with Jeanette in the front passenger seat and Jennifer in the rear passenger seat. The Teagues drove along the Princes Highway towards Melbourne, stopping in Warragul to run a few errands, before continuing on to the Monash Freeway and across the Bolte Bridge to the Tullamarine Freeway. They exited at Kilmore and stopped for lunch, after which Jeanette took over driving. From Kilmore, Jeanette drove northbound along the Northern Highway towards Elmore, passing through Toolleen, travelling approximately 200 metres behind a truck which appeared to be taking the same route.

4. Meanwhile, Kerrie Dehne had departed Moama in her partner's white 2014 Toyota Landcruiser Prado [Prado], with five passengers under the age of 16. She was towing a grey 2009 twin axle tandem trailer [trailer] which was loaded with a Toyota Hilux [Hilux], a three-wheeled motorbike, a large metal toolbox and two red gum sleepers. Ms Dehne passed through Elmore and continued driving southbound on the Northern Highway towards Toolleen

5. Between Toolleen and Elmore, the Northern Highway is a bitumenised road with a north-south orientation and provision for one lane of traffic in each direction, separated by double white lines. The default speed limit is 100 kilometres per hour [kph]. Approximately five kilometres south of Elmore, there is a sweeping bend in the Northern Highway as it crosses Mt Pleasant Creek, which is bordered by Armco railing.

6. At approximately 3:10pm, Ms Deane was crossing the Mt Pleasant Creek bridge [the bridge] when the steering wheel of the Prado began to shudder and shake. The driver of the truck, Leslie Cooper, saw the Prado begin to cross into his lane and so he moved further over to the left to try and avoid it. Mr Cooper noticed the driver of the Prado attempt to correct its path as it narrowly missed his truck.

7. Jeanette was approaching the bridge when she saw the Prado coming from the opposite direction. She noticed that the trailer was 'fish tailing' as the Prado passed the truck, and so she slowed down. Suddenly, the Prado swerved in front of the Jetta. Jeanette had no

time to avoid a collision and the Jetta struck the Prado heavily on the passenger side. The airbags of both cars deployed. The trailer and load disconnected from the Prado due to the force of the collision and rolled into and over the Jetta, causing the Jetta to flip onto its roof. The Prado continued off the western side of the road and onto the grassy verge, where its driver's side struck a large gum tree. The Hilux came off the trailer and rolled several times before coming to rest on its roof on the western side of the road, while the trailer flipped and landed upside down on the eastern side of the road.

8. Mr Cooper saw the aftermath of the collision in his rear view mirror and contacted emergency services. Gareth and Tamara Rattray, who had been travelling behind the Jetta and witnessed the collision, immediately stopped to render assistance. Mr Rattary assisted Jeanette and John to exit the Jetta and moved them a safe distance from the car, before returning to try and extricate Jennifer, who was unresponsive, from the rear of the car, however he was unable to get enough leverage to release her from the seat belt. He then went over to the Prado and assisted the occupants of that car. Shortly afterwards, an off-duty ambulance paramedic arrived at the scene and assisted Mr Rattray to remove Jennifer from the Jetta. Ambulance paramedics arrived soon after and declared Jennifer deceased at the scene.

INVESTIGATIONS

Forensic pathology investigation

9. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Jennifer May Teague, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. The CT showed left scalp bruising and a transection of the lumbar spine with probable associated major vascular injuries. Dr Bedford also noted extensive bruising to the umbilical region, right forearm, left groin, left lateral hip region and anterior right shin.

10. Dr Bedford ascribed the cause of Ms Teague's death to multiple injuries sustained as a passenger in a motor vehicle incident.

Police investigation

11. Upon attending the site of the collision, Victoria Police officers ascertained that the traffic conditions were light, the road was sealed, it was a warm sunny afternoon and the road surfaces were dry. Police officers determined that Ms Dehne was the driver at fault in the collision.

12. Detective Senior Constable (DSC) Leigh Miller was the nominated coroner's investigator.[1] At my direction, DSC Miller conducted an investigation of the circumstances surrounding Ms Teague's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by witness to the incident Tamara Rattray, off-duty ambulance officer Adelle Preston, as well as the Victim Impact Statements of John and Jeanette.

13. In the course of the investigation, police learned that tyre scuff marks on the road and the Armco railing confirmed witness observations that the Prado and trailer were out of control while crossing the Mt Pleasant Creek Bridge. Sergeant Leigh Booth of the Mechanical Investigation Unit inspected the Prado. His inspection did not reveal any mechanical fault with the car which would have caused or contributed to the collision.

14. Detective Leading Senior Constable (D/LSC) Robert Hay of the Major Collision Investigation Unit performed a reconstruction of the collision and assessed the trailer and load. D/LSC Hay noted that the trailer had a Gross Trailer Mass (i.e. maximum carrying capacity) of 2000kg. He determined that the combined weight of the trailer and load at the time of the collision was, at a minimum, 570kg in excess of the allowable combined weight for the trailer. D/LSC Hay also noted that the Prado had a towing capacity rated at 2500kg, therefore the trailer and load exceeded the towing capacity of the Prado by a minimum of 70kg.

15. Crash Data Retrieval extracted from the Prado showed that 3.8 seconds before the collision, the Prado was travelling at 106kph, slowing to 96kph immediately prior to the collision. D/LSC Hay determined that contributing factors to the collision were the

[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator receives directions from a coroner and carries out the role subject to those directions.

excessive speed of the Prado, the excessive weight being towed and the loading configuration of the trailer, which caused the tow ball weight to be low.

16. Ms Dehne was charged with careless driving, severe breach of the mass limit requirements for a trailer and towing an unregistered trailer. She pleaded guilty to all charges at the Bendigo Magistrates' Court, was fined $2000 plus costs and her license was suspended for two months.

17. During the sentencing, Jennifer and John Teague submitted Victim Impact Statements [VIS]. In his VIS, John expressed a wish that his sister's death not be 'just another statistic' and hoped that his family's tragedy 'would serve as an example and as a warning to other drivers as to the risks and responsibilities when towing heavy loads'.

18. In his VIS, John urged the presiding magistrate and coroner to consider recommending actions that would help prevent similar incidents, such as:

    a. *Changes to driver training to include towing techniques and regulations, perhaps even making the towing of loads greater than a light trailer a licence endorsement requiring competency testing.*

    b. *Adding this type of "accident" to the TAC "scenario" advertisements that have been so effective in highlighting other causes of road trauma.*

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. On 5 March 2018, I invited TAC and VicRoads to respond to those comments outlined in John Teague's VIS. On 27 April 2018, TAC and VicRoads were informed by the Court that they must respond by 4 May 2018, as the Finding into the death of Jennifer May Teague was otherwise ready to be finalised. The Court did not receive a response from either institution.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With a view to reducing harm to others and preventing like deaths, **I recommend** that the Transport Accident Commission and VicRoads consider facilitating public awareness campaigns that highlight the dangers of towing an overloaded trailer.

2. With a view to reducing harm to others and preventing like deaths, **I recommend** that the Transport Accident Commission and VicRoads consider any changes to driver licencing training that may include towing techniques.

FINDINGS

The investigation has identified that Jennifer Teague died in circumstances where the driver of an oncoming vehicle lost control and struck the vehicle in which she was a rear seat passenger. Ms Teague was fatally injured in the collision and died at the scene.

On 7 December 2017, Kerrie Dehne pleaded guilty to charges of careless driving which ultimately caused the death of Ms Teague. Additionally, Kerrie Dehne pleaded guilty to charges of towing an unregistered trailer and a severe breach of the mass limit requirements of towing a trailer. Kerrie Dehne was convicted and fined $2000 and her licence to drive was suspended for two months.

I accept and adopt the medical cause of death ascribed by Dr Bedford and I find that Jennifer May Teague died from the multiple injuries she sustained as a rear seat passenger in a motor vehicle incident.

Pursuant to sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that these Findings be published on the internet.

I direct that a copy of this finding be provided to the following:
Beth Crossman
Latrobe Regional Hospital
Office of the Chief Psychiatrist
Detective Senior Constable Leigh Miller
VicRoads
Transport Accident Commission

Signature:

AUDREY JAMIESON
CORONER
Date: **15 May 2018**

Coroners Court of Victoria