IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 005084

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**KAREN MARIE RYAN**
Date of birth:	4 August 1967
Date of death:	25 October 2017
Cause of death:	1(a) NECK TRAUMA (MOTOR VEHICLE IMPACT – DRIVER)
Place of death:	Longwarry North, Victoria

HER HONOUR:

Background

1. Karen Marie Ryan was born on 4 August 1967. She was 49 years old when she died in a motor vehicle accident.

2. Ms Ryan is survived by her sons Daibidh Gillies and Joshua Ryan. She was a foster mother to twins Annabelle and Dwight Miller-Bunker and a kinship carer of her niece Indie Slater.

3. At the time of her death Ms Ryan was engaged to her partner Martin Rands. Mr Rands lived separately from Ms Ryan but often stayed at her house.

4. Ms Ryan had a medical history of Type 2 diabetes mellitus, polycystic ovarian syndrome, hypertension, anaemia and obstructive sleep apnoea.

The coronial investigation

5. Ms Ryan's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms Ryan's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

10. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

11. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

12. On 25 October 2016 Ms Ryan left her house at 3.20pm to collect her son Joshua, two foster children and a child then under her kinship care from Labertouche Primary School.

13. Earlier that day she and Mr Rands were chatting *'quite happily'* at her house and she seemed *'her normal self'*. Ms Ryan left on time to pick up the children and was not in a rush. According to her fiancé she always ensured she had the correct child seats fitted in her car and was generally a good driver. Ms Ryan drove a white Hyundai van.

14. At 3.25pm Mr Andrew Bransgrove was driving his Kenworth truck in a westerly direction on Princes Way, Longwarry North, toward Sand Road on his left. Sand Road terminated at Princes Way and had a T intersection advisory sign and stop sign. There was also arrow signage on Princes Way facing Sand Road drivers indicating they must turn right or left.

15. As he approached the intersection Mr Bransgrove observed a couple of cars coming out of Sand Road and turning right onto Princes Way travelling east towards Drouin. He reduced his speed to approximately 80 km per hour. He intended to travel past Sand Road and was driving close to the centre line of the traffic island. At this location Princes Way westbound separates into two lanes, one for traffic turning left into Sand Road and one for vehicles continuing straight ahead as Mr Bransgrove intended.

16. Mr Bransgrove saw a white van, which was Ms Ryan's vehicle, approaching the intersection from Sand Road. He saw Ms Ryan's van slow down and then enter the intersection directly in front of him. Mr Bransgrove swerved to the right thinking Ms Ryan would see him and stop, however she continued into the path of westbound traffic and then stopped. Mr Bransgrove then swerved to the left in an attempt to avoid the van. He braked hard but sadly collided with Ms Ryan's van. The front of his truck impacted the driver's side of her van.

17. Mr Bransgrove, was physically unharmed in the accident. He checked Ms Ryan who was not responsive. Passing motorists and local residents who heard or saw the accident came to the scene. Construction workers at a nearby worksite, one of whom witnessed the accident from afar, went to assist Ms Ryan and performed cardio-pulmonary resuscitation until emergency services arrived. Tragically Ms Ryan could not be revived and was declared deceased at the scene.

Identity of the deceased

18. Ms Ryan was visually identified by her partner Mr Rands on 25 October 2016. Identity was not in issue and required no further investigation.

Medical cause of death

19. On 27 October 2016, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy of the body of Karen Ryan. The autopsy revealed traumatic neck and head injuries. Significant natural disease was also identified (including an incidental finding of pancreatic cancer) but none which would have contributed to the accident.

20. Toxicological analysis of post mortem specimens taken from Ms Ryan identified a therapeutic level of venlafaxine (an antidepressant) and its metabolite.

21. After reviewing toxicology results, Dr Dodd completed a report, dated 29 December 2016, in which he formulated the cause of death as '1(a) neck trauma (motor vehicle impact – driver)'. I accept Dr Dodd's opinion as to the medical cause of death.

Cause of the collision

22. Victoria Police undertook a mechanical inspection of both vehicles following the collision. Ms Ryan's van was roadworthy, however its airbags had not deployed in the collision. The truck was also in a roadworthy condition prior to the collision. The truck had recently been serviced and was found to have no mechanical issues at the time of service.

23. Visibility was clear and the weather fine on the day of the collision. There was light traffic and the road was in good condition. Neither driver was affected by illicit drugs or alcohol.

24. At the intersection where the collision occurred Princes Way has a sealed bitumen surface. It is a straight length of road running east to west which has a 100 km per hour speed limit. The road markings were faded and in some places absent altogether at the time of the collision, although I am advised they have since been re-painted.

25. Sand Road has a sealed bitumen surface and runs north to south between Princes Highway and Princes Way. It has a 60 km per hour speed limit. The stop sign is positioned approximately 10 metres prior to the actual stop line at the intersection with Princes Way.

26. Mr Bransgrove reported that most vehicles travelling west on Princes Way turn left into Sand Road. Ms Ryan was well familiar with the intersection. It is possible that she wrongly assumed that Mr Bransgrove's truck was going to turn left, although I am satisfied he was not indicating to do so.

27. The investigating member commended to the Victoria Police Fatal Collision Audit a number of suggested improvements to this intersection; namely re-painting the road markings, reducing the speed limit on Princes Way to 80 km per hour and lengthening the westbound left turning lane, thus making a driver's intention more apparent. As I observed above, the road markings have since been re-painted, however the speed limit on Princes Way remains 100 km per hour and no changes have been made to the westbound left turning lane. Therefore I make a recommendation directed to the local shire council to consider these suggested improvements. I also direct that a copy of this Finding be provided to the Transport Accident Commission for their information.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Karen Marie Ryan, born 4 August 1967;

(b) Ms Ryan died on 25 October 2016 at Longwarry, Victoria, from neck trauma (motor vehicle impact – driver); and

(c) the death occurred in the circumstances described above.

Recommendations

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

1. I recommend the Baw Baw Shire Council examines the traffic patterns at the intersection of Princes Way and Sand Road, Longwarry North, to determine the need for a reduction in the speed limit and lengthening the westbound left hand turn lane on Princes Way.

Publication

Given that I have made recommendations I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Ms Ryan's family.

I direct that a copy of this finding be provided to the following:

Martin Rands, Senior Next of Kin

Baw Baw Shire Council

Transport Accident Commission

Mr Damien Christmas, Zurich Insurance

Leading Senior Constable Simone Schroder, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 12 January 2018