FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 425/08

In the Coroners Court of Victoria at Melbourne

I, **JANE HENDTLASS**, Coroner

having investigated the death of:

Details of deceased:

Surname: **FORDE**
First name: **MATTHEW**
Address: Unit 9, 400 St Kilda Road, St Kilda, Victoria 3182

without holding an inquest:

find that the identity of the deceased was **MATTHEW THOMAS FORDE** born 16th February 1978 and death occurred on 29 January 2008 at the Alfred Hospital, 55 Commercial Road Melbourne Victoria 3004

from

1a. **HEAD INJURY**

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

Mr Matthew Forde was 29 years old when he died. He lived with his domestic partner, Cherry Wang, at Unit 9, 400 St Kilda Road in St Kilda. Mr Forde worked as a transport design engineer.

At about 10.00am on 28 January 2008, Mr Forde and Ms Wang were in Altona North driving to Torquay along the Princes Highway with two surfboards tied on to the roof rack of the car. In this location, Princes Highway has five lanes in each direction.

When Mr Forde's car was between Doherty's Road and Kororoit Creek Road, one of the surfboards fell off the roof rack on to Lane 3 of the south-bound carriageway. Mr Forde pulled

into the left hand emergency lane of the Princes Highway and he and Ms Wang got out of their car to retrieve the surfboard. Mr Forde walked quickly back down the left hand emergency lane, looking towards the surfboard. Ms Wang followed some distance behind him.

At the same time, Leonard Grass was driving his VicRoads road maintenance van south on the Princes Highway. Mr Grass's job was to check the roads for any damage or defects and hazardous objects that are obstructing free flow on the roadway. His VicRoads van was fitted with flashing overhead lights and a reversing sensor to warn the driver if he was backing into an object. However, Mr Grass has a hearing problem which may have interfered with his response to the reversing sensor. Further, the van was not fitted an externally audible alarm which operates when the vehicle is reversing.

When he saw Mr Forde's surfboard lying on the second lane of the Princes Highway, Mr Grass pulled his van into the left emergency lane with its flashing overhead lights activated. He then used his rear vision mirror to reverse his van back along the left hand emergency lane towards the surfboard. Mr Grass said he intended to find a break in the traffic so that he could move on to the right hand shoulder to more easily retrieve the surfboard. Although Mr Grass says he was travelling at about 20-25kph, witnesses say that he was travelling very fast for a reversing vehicle, possibly about 30-40kph.

Witnesses also say that neither Mr Forde nor Mr Grass seemed to be aware that the other was present. Mr Grass confirmed that he did not see Mr Forde because he was watching the traffic and the object in the middle of the road through his right hand rear view mirror. I am unable to say whether the reversing sensor in Mr Grass's van was activated when it was approaching Mr Forde.

After travelling about 30 metres in reverse in the left hand emergency lane of the Princes Highway, Mr Grass's van hit Mr Forde. Mr Grass thought he had hit the safety cable on the left hand side of the emergency stopping lane and continued to reverse until he looked to the front of his vehicle and saw Mr Forde lying on the emergency lane in front of him. Mr Grass then called emergency services.

Mr Forde was unresponsive at the scene. At 11.00am, he was resuscitated and transported to The Alfred Hospital. However, CT scans indicated that Mr Forde had suffered unsurvivable closed head injuries.

At 4.50am on 29 January 2008, Matthew Forde died.

An application for no autopsy to be performed was granted by the Coroner. The forensic pathologist who inspected the body and the post mortem CT scans formed the opinion that a reasonable cause of death would appear to be head injury.

Toxicological analysis of blood taken at 11.00am on 28 January 2008 detected caffeine at a concentration of 9mg/L which is over twice the concentration usually detected with normal use of caffeine based beverages.

On 27 January 2009, Mr Grass was convicted of careless driving in the Sunshine Magistrates' Court. He was fined $1000.

In commenting on the circumstances of Mr Forde's death, I note that Mr Grass was an employee of VicRoads and he was driving a VicRoads vehicle. I also note that Mr Grass says that his job included removal of safety hazards on the highway. Although this role would frequently require a person in Mr Grass's position to reverse in the emergency lane of the highway, his vehicle was not fitted with an externally audible reversing alarm.

Mr Forde would have been made aware of the approach of Mr Grass's reversing vehicle if it had been fitted with an externally audible reversing alarm. Therefore, pursuant to Section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

RECOMMENDATION

VicRoads consider routinely fitting their road maintenance vehicles with an externally audible alarm which operates when the vehilce is reversing.

Signature:

Dr Jane Hendtlass
Coroner
5 January 2010

Distribution: Attorney General of Victoria
Minister for Roads and Ports