IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 0454

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Deceased:	**NICHOLAS WALTER MONGTA**
Delivered on:	June 26 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	19 July 2016 and 16 January 2017
Findings of:	**CORONER PETER WHITE**
Representation:	Damian Coddognotto appeared to assist the family of Chistopher Reddin. Mr R Donaldson of Counsel appeared on (16 Januray 2017), on behalf of VicRoads
Assisting the Coroner:	Jodie Burns Solicitor on 19 July 2016 and Leading Senior Constable Tracey Ramsey on 16 January 2017.
Catchwords:	Mandatory inquest, methylamphetamine, motor vehicle collision.

BACKGROUND

1 Nicholas Walter Mongta, 22 years of age, died on 28 January 2015 at approximately 6.30am when the vehicle in which he was travelling, driven by Joshua Taylor, collided with a tree on the Northern Highway in Pyalong. The driver and the other two passengers, Christopher Reddin and Corey Bray, also died at the scene.

THE PURPOSE OF A CORONIAL INVESTIGATION

2 Nicholas' death constituted a '*reportable death*' under the *Coroners Act 2008* (**the Act**), as his death occurred in Victoria, and was both unnatural and as a result of injuries sustained from a motor vehicle accident.

3 The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

4 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[2] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

5 The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

6 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

7 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

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[1] Section 89(4) *Coroners Act 2008.*
[2] *Keown v Khan* (1999) 1 VR 69.

8 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[3] 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 that they caused or contributed to the death.

9 Under section 52(2)(a) of the Act, a coroner is required to hold an inquest into the deaths of the passengers of the vehicle, including Nicholas, as I suspected that the deaths occurred as a result of Joshua Taylor's driving whilst under the influence of illicit drugs.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

10 Nicholas was identified by DNA testing. On the basis of the statement of Zoe Bowman, scientist in molecular biology at the Victorian Institute of Forensic Medicine, I am satisfied that the deceased is Nicholas Walter Mongta, born on 13 March 1992.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

11 Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. Dr Lynch provided me with a report of his findings. Dr Lynch reported that the post mortem CT scan revealed a fractures of mandible, pelvis, ribs, right and left femora and right haemopnumothorax. Post mortem toxicology testing showed the presence of methylamphetamine at 4mg/L in blood and amphetamine at 0.5 mg/L in blood. Dr Lynch concluded that the cause of Nicholas's death was 1(a) injuries sustained in a motor vehicle collision. I adopt Dr Lynch's findings as to the medical cause of death.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

12 On 28 January 2015, at approximately 6.30am, a silver 2001 model Holden Commodore sedan was being driven by Joshua Taylor in a northerly direction along the Northern Highway towards the main township of Pyalong. Corey was seated in the front passenger seat and Christopher and Nicholas were in the rear passenger seats of the vehicle. Corey appears to have been the only occupant wearing a seat belt.

[3] (1938) 60 CLR 336.

13 As Joshua approached a left hand uphill bend he has drifted across the southbound lanes. The vehicle left the road to the right and travelled onto the grassed shoulder then continued on a straight path before striking a *proprietary flex fence wire rope barrier.* It then travelled down an embankment and impacted the ground below. The force of the impact has caused the vehicle to rotate forward and in an anti-clockwise direction tipping the vehicle onto the driver's side. The vehicle continued north where it has struck a tree that impacted with the roof of the vehicle. The vehicle ultimately came to rest against a tree with the front bumper of the vehicle on the ground and the boot of the vehicle against the tree.

14 Witnesses to the collision called emergency services. Police, firefighters and paramedics attended the scene however it was clear that all four occupants were deceased.

15 Toxicology testing showed the presence of methylamphetamine and amphetamine in Nicholas, Corey and Christopher. Methylamphetamine and amphetamine was also found in Joshua Taylor. Dr Morris Odell provided the opinion that the blood level of methylamphetamine in Joshua after death was extremely high and would have produced a severe detrimental effect on his ability to drive safely.

16 Police located a substance in the vehicle that was later proved to be methylamphetamine.

17 The Major Collision Investigation Unit attended the scene. Detective Acting Sergeant Philip Frith provided a statement and noted that the road was dry, the weather was fine and clear and visibility was excellent. The speed limit for the section of the northern Highway was 100kmph. There was no evidence that the driver of the vehicle input any steering or braking at the commencement of the left curve. There was also no evidence that the driver reacted to crossing the audible tactile strip designed to alert a distracted driver of lane crossing. Detective Acting Sergeant Dr Jenelle Mehegan also provided a statement and noted that the pre impact vehicle movements were consistent with a driver who is asleep, unconscious or affected by drugs and/or alcohol.

18 Fixed speed cameras detected the vehicle travelling above the speed limit on 28 January 2015 at 2.07am, 5.27am and 5.50am, that is, prior to the collision.

19 The vehicle was inspected by Leading Senior Constable Ian Ellis and was classed as being in reasonable condition. Leading Senior Constable Ian Ellis stated that his inspection did not reveal any mechanical fault with the vehicle that would have caused or contributed to the collision.

20 Following a post mortem examination and a screen for drugs and alcohol, I note that the driver of the vehicle Joshua Taylor, was found to have had a level of 1.0mg of methyl amphetamine in his blood. Dr Morris Odell's evidence was to the effect *that the blood level of methyl amphetamine associated with the second collision was extremely high and would have produced a severe detrimental effect on his ability to drive safely.* He further stated that in respect of his earlier injuries sustained in his first collision in November, 2014, *that there is no evidence in the medical record to suggest that he suffered any long term impairment from the head injury in the first collision.*[4]

21 Detective Leading Senior Constable Cameron Merrett (MCIU) testified as to his role as the Coroner's investigator and provided a reconstruction of the events under examination. He stated that from the rolling tyre prints across the corner of the base plate and factoring in the direction the vehicle was travelling, that it was the vehicle's left front tyre that had first struck the base plate. His further belief was that the finding of a distinct green mark and damage to the front bumper bar of the car, before the bumper bar was dislodged, again indicated that the impact with the first of the upright posts occurred at the left-hand side of the vehicle.

22 D/L/S/C Merrett further testified as to his belief that the vehicle had previously travelled across the opposite carriageway and then off the edge of the road, before the initial collision had occurred. He also explained that there were no marks identifiable on the road surface, or on the grass (i.e. rolling tyre prints, which are distinctly different to a skid), and that it was not possible to establish where the vehicle had commenced to leave the correct side of the road and further no evidence to suggest that brakes were applied either before or after the vehicles wheels had left the road surface.

23 Immediately before the accident, Joshua Taylor was driving along a relatively straight area of road of approximately 200-250 metres and going slightly up hill, this prior to the sweeping left-hand bend. As above it was also the case that there was no evidence to establish that the vehicle had been caused to slow and accordingly no evidence to suggest that excessive speed at this time had contributed to the accident.

24 D/L/S/C Merrett additionally testified that it there was daylight at 6.30am, the time of the accident, and that it was dry. His further belief was that the vehicle, weighing some 1700 kilos, had become airborne before the collision. He also testified that the roadway immediately adjacent to the barrier fell away sharply and that this was the reason why the

[4] Statement at exhibit 4 page 108.

vehicle had become airborne before colliding with a tree and coming to rest, and that there was no deployment of airbags. If the vehicle had struck the tree headfirst, D/L/S/C Merritt believed that the vehicle's air bags would have been deployed.

25 His further opinion (in respect of an area of knowledge in which he was not considered to be expert), was that wire barriers of the kind struck by this vehicle were designed to keep vehicles on the road, or to protect them from going further off the road. They were not there to provide protection to vehicles travelling in an opposite carriage way as this one was or indeed to protect any vehicles as such, but rather that the posts were there to hold the wire up. He further explained his view that once a vehicle impacts the wire, the posts fall away and the vehicle uses the stretch of the wire to allow it to stay within the confines of the road, and not end up away from the road or on an adjacent carriage-way.

26 During cross-examination of Mr Merrett it was suggested that the design of the barrier had in fact created a danger to the vehicle and its incumbents and this had contributed to the collision, which had led to the loss of these 4 young lives.

27 Following this examination, Ms Burns, Solicitor Assisting, then successfully sought an adjournment to seek further evidence in respect of this matter. Following the receipt and circulation of a statement from a Mr Malcolm Kersting a regional Director with Vic Roads the Inquest resumed on 16 January 2017 to allow for additional examination on this issue. Mr Kersting, who was given leave to provide expert evidence,[5] testified that the earlier reference by VicPol, to the barrier being a Brifen barrier was not correct and that it was instead a *proprietary flex fence wire rope barrier, known as a flex fence.* As to the reasons for its installation, Mr Kersting further stated that the highway in question was typically a single carriageway with one lane in each direction. It was classified as a Class B arterial road and used by about 3700 vehicles per day, which included approximately 650 commercial vehicles.

28 The flex fence barrier under examination was situated between Kilmore and Pyalong, near Pyalong and was developed to treat high risk areas identified and evaluated in accordance with the project and the then existing guidelines. In total the project included the installation of more than seven kilometres of safety barriers, wire rope safety barriers and steel guard fences. The barriers were installed over the project length of 20 kilometres along the highway, at a total of 27 locations and were approved by VicRoads for installation in higher severity zones, most particularly at the location of the accident site, where there were significantly

[5] Transcript page 22.

mature gum trees within five meters of the road on its eastern side and a substantial depression, this depression leading away from the south bound road surface towards open farming country.

29 This particular barrier was installed in 2006, *principally to protect south bound vehicles from the hazards*, off their side of the road as described above, that is hazards adjacent to the southbound carriageway, opposite to the carriage way in use at the time of this accident. 6 The end treatment at the Pyalong location was an accepted end treatment at that time.

30 Mr Kersting explained that during an impact the wire rope safety barrier contains an errant vehicle by deflecting transversely after the supporting post yield and release the ropes, which then redirect the vehicle away from the hazard, with the wire ropes expected to stretch and absorb the force of a colliding vehicle. Further, *this energy absorbing process means that an occupant of an errant vehicle is less likely to suffer injury, than colliding with a rigid barrier.*7

31 Mr Kersting additionally testified as to the distinction between the wire rope safety barrier and the different gating end treatment or terminal treatment, now sometimes employed. In this regard he described how terminals for steel guard fences are often installed on a flair that is curved away from the roadway. His further opinion was that curved away or breakaway terminals, *would not have made any difference to the subject site. The end treatment is flared at the entry end of the guard fence, not at the departure end.*8

32 Mr Kersting then testified as to the barriers compliance with then existing safety standards, both at National and State level and to the fact that the barrier under examination, *appears to have performed to the manufacturer's expectations.*

33 In conclusion he testified as to his belief in the absence of any defect in the barrier and also observed that, *the outcome of the accident may have been different if the wire rope safety barrier had been extended for a further five to ten meters to the south, which may have played a role in preventing the vehicle from leaving the roadway. However the risk of a north bound vehicle errantly crossing to the south bound lane* (into the path of oncoming traffic) *and then leaving the road, would not have been the primary consideration in Vic Roads assessment of the desirability of establishing a wire rope safety barrier at the Pyalong location.*[9]

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[6] See exhibit 2 page 2 and Transcript 35.
[7] Ibid page 2-3.
[8] Ibid page 3.
[9] Ibid page 4.

34 *However with the introduction of the safe system principles, it is now recognised that all hazards may cause injury to occupants of an errant vehicle. These principles include increased focus on vehicles crossing to the wrong side of the road centre line and interacting with vehicles travelling in the opposite direction, or hazards beyond the road formation to the right hand side.*[10]

35 Mr Donaldson of Counsel on behalf of VicRoads presented certain photographs of the scene setting out the path taken by the vehicle together with the surrounding environment and the front of the vehicle down against a tree position, where the vehicle had come to rest.[11]

36 Mr Codognotto on behalf of the family of Christopher Redden, then further examined Mr Kersting on the elevation of and the length of the cable to the end block at the southern end of the barrier, (into which the vehicle initially collided). This questioning was aided by a series of photographs of the scene taken of the roadway and barrier with the base plate at the southern end of the barrier, and the wire rope extending from the base plate for a distance of 4.35 meters to the first upright post.12 Mr Codognotto suggested that there were a substantial number of trees in the area and that the wire barrier at its southern end should have been extended by 10 to 15 meters. Mr Kersting agreed that if such had been the case, it was conjecture, *but all of the occupants may have survived.*13

37 Mr Codognotto also suggested that the elevation to the first block when met by the left front side of the vehicle would cause a ramp with, *the vehicle catapulted into the air... So once it goes there it is airborne and strikes the tree roof first*? Mr Kersting who confirmed that he was not an expert in accident reconstruction, did not directly respond to these questions. He did however agree that if the car had gone off the road without the barrier in place that he would have expected the airbags to deploy.

38 It was further confirmed that Christopher Reddin was believed to be one of two passengers sitting in the rear of the vehicle, with only the passenger in the front seat wearing a seatbelt.

39 Mr Kersting was then questioned about more recently designed wire rope barrier systems. He stated that the newer systems (he believed there were three), had the same four tensioned wires but a greater number of posts graduating in height to the full height of the barrier, which design he believed possessed the same ability, *to crumple or bend when struck.* Mr Kersting was also questioned about his observation at the scene that the first of the tyre marks on the

[10] Ibid page 5.
[11] Exhibit 2a photographs 1-6.
[12] Transcript page 24. Exhibit 2b a diagram and joined series of photographs of the accident scene, submitted by Mr Codognotto.
[13] Transcript 32.

grass below the wire flex battier were located approximately 7 and 1/2 to 10 meters from the first upright.[14]

40 Mr Kersting also testified as to the improved statistical results, reference death and serious injury, following the introduction at this location of the wire rope barrier system. *The conclusion is that the wire rope safety barrier systems are a significant contributor to reducing the risk of crash and severity of crash on our roads.*

41 The witness further testified as to the development of programmes to introduce centre carriageway safety barrier fences to seek to control the movement of vehicles which, like this one, move across the centreline of dual carriageways (potentially) into the path of oncoming vehicles. This development was part of the safe system approach taken by VicRoads, which encompasses the contemplation that a *run off to the right* accident, such as this one, may occur.

42 Following the conclusion of this evidence certain further materials, which included a parliamentary report, photographs and the remainder of the brief, were submitted to the Court. The Court then heard submissions for VicRoads and Mr Codnognotto on behalf of the Reddin family.

43 In his submission, I note Mr Condognotto's entirely responsible statement on behalf of the family of Christopher Reddin, in respect to the use of drugs before or while driving. His further submission was to the effect that both the positioning and the design of the wire rope barrier system contributed to the severity of the accident, and to the resulting tragedy. Later an additional written submission was received from Mr Donaldson for VicRoads, with certain additional materials all supplied to the interested parties and submissions in reply received thereafter.[15] I have considered these matters and thank Mr Condognotto and Mr Donaldson for their submissions.

[14] Transcript 47.
[15] See discussion with parties at transcript and VicRoads submission dated 25 January 2017 and reply from Mr Condognotto for the Redden family dated 3 February 2017.

FINDINGS

44 Having investigated the death of Nicholas Walter Mongta and having held an inquest in relation to his death on 19 July 2016, at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) That the identity of the deceased was Nicholas Walter Mongta, born 13 March 1992.

(b) That Nicholas Walter Mongta died on 28 January 2015, at the Northern Highway in Pyalong from injuries sustained in a motor vehicle collision, in the circumstances described above.

(c) That neither the positioning or the design of the Wire Rope Flexi Barrier into which the vehicle first collided, were factors which have been shown to have caused or contributed to this accident. I find rather that this accident was caused as a result of the failure to control the movement of a vehicle by a young and inexperienced driver, whose earlier consumption of methyl amphetamine had severely impacted upon his ability to maintain a proper level of control over his vehicle.

(d) That the various decisions made by VicRoads concerning the introduction of this programme of road improvement, were proper and reasonable and in the public interest.

45 I find then that these four young lives were needlessly lost in the manner described above and that the circumstances of this case again highlight the dangers of the use of methyl amphetamine, in particular, in the context of driving.

46 It is also the case that I am satisfied that all passengers were effected by their earlier substance abuse and as a result appear to have lost their ability to make appropriate judgements as to whether to join in the decision to undertake or to continue, on this particular journey.

47 In so finding I note with approval that various state wide programmes for road improvement have now broadened their perspective to allow for additional consideration to be given to *run off* type accidents such as this. I also acknowledge that all such accidents cannot be avoided but observe that there appears to be a potential for the further reduction of the risk of accident in appropriate settings in rural areas, this by various means, which may include the introduction of highway centreline Wire Rope Flexi Barriers.

48 I express my sincerest sympathy to the family and friends of Nicholas Mongta.

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

(a) The Family of Nicholas MONGTA

(b) Ms Karen McDonald, VicRoads

(c) Detective Leading Senior Constable Cameron Merrett, coroner's investigator.

Signature:

PETER WHITE
CORONER

Date: 27 June 2017.