IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5068

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**NICOLE AMANDA CHATFIELD**
Date of birth:	6 April 1971
Date of death:	24 October 2016
Cause of death:	Multiple injuries (motor vehicle impact – driver)
Place of death:	Pakenham South, Victoria

HER HONOUR:

Background

1. Nicole Amanda Chatfield was born on 6 April 1971. She was 45 years old when she died from injuries sustained in a motor vehicle incident in which she was a driver.

2. Ms Chatfield lived in Nar Nar Goon with her partner, Georgette McCreath. She worked at the hardware store in Pakenham South, approximately a seven-minute drive away from her house. Ms Chatfield also enjoyed working on her farm.

3. Ms Chatfield had a limited medical history, and was generally healthy. She was prescribed citalopram, an antidepressant, for anxiety.

The coronial investigation

4. Ms Chatfield'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.

5. 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]

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

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

[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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms Chatfield's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

9. 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.

10. 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.

Identity of the deceased

11. Ms Chatfield was visually identified by her mother, Heather Chatfield, on 27 October 2016. Identity was not in issue and required no further investigation.

Medical cause of death

12. On 26 October 2016, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Ms Chatfield after reviewing a post mortem computed tomography (CT) scan. The autopsy revealed extensive musculoskeletal trauma, haemorrhage around and within the brain, and significant internal blood loss in the form of haemothoraces. No significant naturally occurring disease was identified.

13. Toxicological analysis of post mortem specimens taken from Ms Chatfield identified citalopram at therapeutic levels. No other common drugs or poisons were detected.

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

Circumstances in which the death occurred

15. On 24 October 2016 at approximately 4.15pm, Ms Chatfield left her work at the hardware store on Five Mile Road, Pakenham South. Her manager, Andrew Walsh, let her leave earlier than her normal time of 4.30, as they were having issues with the store's computer system. Mr Walsh noticed that Ms Chatfield was flustered by the issues. Ms Chatfield left work in her car, a 2002 Ford Falcon.

16. Ms Chatfield drove north on Five Mile Road. Approximately one minute after leaving work, she approached the intersection of Hall Road and Five Mile Road. This intersection was governed by a 'stop' sign facing Ms Chatfield.

17. At the same time, Christopher Collins was driving a 2004 Ford Territory west along Hall Road. As Mr Collins approached the intersection with Five Mile Road, he saw Ms Chatfield's Ford Falcon enter the intersection. Mr Collins braked heavily, but was unable to avoid a collision, and his car hit the driver's side of Ms Chatfield's car. Both vehicles spun across the road and hit a fence.

18. Another witness described Ms Chatfield's car as driving into the intersection without stopping or slowing. He estimated that both vehicles were travelling at around 80km per hour at impact.

19. Mr Collins exited his car. Other drivers stopped and emergency services were contacted. Victoria Police officers, the State Emergency Service (SES) and the fire brigade attended the scene.

20. Ms Chatfield was removed from her car by emergency services and placed on a stretcher. Unfortunately, she could not be revived, and was declared deceased.

21. Victoria Police reviewed the scene. They observed Five Mile Road to be a gravel road with no line markings, running in a north-south direction. It had a grass shoulder and farmland on both sides. A line of trees on the eastern side impaired visibility of traffic travelling west along Hall Road towards the intersection. A sign warning of an upcoming 'stop' sign on the western sign of the road was situated approximately 174 metres from the actual 'stop' sign at the intersection with Hall Road. The stop sign and advisory signs on Five Mile Road were in good condition.

22. Hall Road was a gravel road with no line markings, running in an east-west direction. It also had a grass shoulder on both sides of the road. There was a cross intersection warning sign on the south side of the road, approximately 100 metres from the intersection with Five Mile Road.

23. Police noted that visibility for drivers on both Hall Road and Five Mile Road was obscured by a wind break comprised of trees on the south-eastern corner of the intersection. In

addition, the intersection was slightly raised to allow Hall Road to cross a drain running parallel to Five Mile Road, which police considered added to visibility problems and loss of traction.

24. The evidence indicates that Ms Chatfield failed to stop or slow at the intersection of Five Mile Road and Hall Road. As she was familiar with the intersection it is not clear why this occurred, other than possibly momentary inattention.

Findings

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

(a) the identity of the deceased was Nicole Amanda Chatfield, born 6 April 1971;

(b) Ms Chatfield died on or about 24 October 2016 at Pakenham South, Victoria, from multiple injuries (motor vehicle impact – driver); and

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

Comments

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

1. It is possible that better visibility may have assisted in avoiding, or reducing the impact of the collision. In particular a better view may have alerted Ms Chatfield to the need to stop and/or may have alerted Mr Collins to the fact that Ms Chatfield was not slowing, allowing him to take evasive action. The investigating police suggested several improvements to the design of the intersection, namely:

a) That a speed limit sign be posted approximately 200 metres from the intersection of Hall Road and Five Mile Road, in both directions, with a reduced speed limit of 80kph for drivers travelling through the intersection.

b) That tree lines immediately south-east of the intersection be removed to improve the line of sight of drivers approaching the intersection.

c) That a review be conducted into the structure of the intersection, particularly the need to have the intersection raised as a result of the drain running parallel to Five Mile Road.

Recommendation

Pursuant to section 72(2)) of the *Coroners Act 2008*, I recommend that Cardinia Shire Council review the design and layout of the intersection of Five Mile Road and Hall Road in light of the circumstances of this collision and the improvements suggested above.

Publication

Given that I have made a recommendation, 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 Chatfield's family.

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

Georgette McCreath, Senior Next of Kin

Senior Constable Andrew Lean, Coroner's Investigator, Victoria Police

Cardinia Shire Council

Brooke Nicholson, RACV Insurance

Signature:

ROSEMARY CARLIN
CORONER
Date: 13 February 2018