IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3115

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**Coroner Darren J Bracken**
Deceased:	**Ms Emma Louise Saunders**
Date of birth:	7 March 1995
Date of death:	1 July 2017
Cause of death:	Ruptured Myocardium in Motor Cycle Incident
Place of death:	25 Wappan Court, Bonnie Doon, Victoria

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HIS HONOUR:

BACKGROUND

1. On 1 July 2017, Emma Louise Saunders was 22 years old when she died from an injury she sustained while she was riding a motorcycle at low speed at a friend's property in Bonnie Doon, Victoria.

2. Ms Saunders had a medical history of asthma, right knee dislocation and right knee reconstruction. She worked as a primary school teacher, was a popular member of the local community.[1]

THE CORONIAL INVESTIGATION

Coroners Act 2008

3. Ms Saunders' death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) as her death occurred in Victoria, was unexpected and was not from natural causes.[2]

4. The Act requires a coroner to investigate reportable deaths such as Ms Saunders' and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[3]

5. For coronial purposes, "*circumstances in which death occurred*",[4] refers to the context and background to the death including the surrounding circumstances, rather than being a consideration of all circumstances which might form part of a narrative which culminated in the death. Required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

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[1] Coronial Brief of Evidence, Statement of Mrs Michelle Saunders dated 15 December 2017.
[2] *Coroners Act 2008* (Vic) s 4.
[3] *Coroners Act 2008* (Vic) preamble and s 67.
[4] *Coroners Act 2008* (Vic) s 67(1)(c).

6. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[5] It is not the Coroner's role to determine criminal or civil liability,[6] nor to determine disciplinary matters.

7. One of the broader purposes 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 making recommendations.

8. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[7]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[8] and

   (c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9]

Standard of Proof

9. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[10] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[11] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "Briginshaw Standard" or "Briginshaw Test" and use of such terms may mislead.[12]

10. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence

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5 *Keown v Khan* [1999] 1 VR 69.
6 *Coroners Act 2008* (Vic) s 69 (1).
7 *Coroners Act 2008* (Vic) s 72(1).
8 *Coroners Act 2008* (Vic) s 67(3).
9 *Coroners Act 2008* (Vic) s 72(2).
10 (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
11 *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
12 *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

commensurate with the gravity of the facts sought to be proved and the finding to be based on those facts.[13] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[14] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[15]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

11. On 1 July 2017, Mr Rafferty Visser identified the deceased as his partner of about 5 years, Emma Louise Saunders. Ms Saunders' identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

12. On 4 July 2017, Dr Michael Burke, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Saunders' body. Dr Burke provided a written report, dated 17 August 2017, in which he opined that the cause of Ms Saunders' death was '*ruptured myocardium in motor cycle incident*'.

13. In his report, Dr Burke commented that the post mortem examination showed no significant bruising to the chest; however, there was a 'buckle' type fracture to the sternum identified on the post mortem CT scan.[16] Dr Burke reported that this injury reflects the application of blunt force, which may have occurred during the initial incident, when Ms Saunders fell off the motorcycle or it could have occurred as a result of resuscitation efforts.

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[13] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[16] The sternum or breastbone is a long flat bone located in the central part of the chest. It connects to the ribs via cartilage and forms the front of the rib cage, thus helping to protect the heart, lungs, and major blood vessels from injury.

14. Dr Burke identified that two possibilities exist to explain Ms Saunders' death. The first being that she may have suffered a cardiac arrest secondary to forceful impact to her sternum, i.e. *commotio cordis.*[17] While the second relates to the rupture of her heart which may have occurred secondary to cardiopulmonary resuscitation (**CPR**), or alternatively occurred secondary to the impact, presumably from the motor cycle's handlebars.

15. Toxicological analysis of post mortem samples was negative for common drugs and poisons.

16. I accept Dr Burke's opinion.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

17. On 30 June 2017, Ms Saunders and her partner, Mr Rafferty Visser, arrived at a friends' 'weekender' in Bonnie Doon, Victoria. The plan was for the couple to stay on the property with a group friends for the weekend;[18] it was the first time Ms Saunders had been there.[19] About an hour after arriving Ms Saunders had one drink around the campfire before heading to bed around 1.30am.

18. On 1 July 2017 at about 11.00am, Ms Saunders travelled to Mansfield with Mr Visser and a group of friends to purchase food; returning around 1.30pm. Upon their return the group sat around talking and relaxing before Ms Saunders asked to ride one of the off-road motor cycles. Ms Saunders was an inexperienced rider and told the others that she had previously only ridden motor cycles when she was younger.[20]

19. At about 2.00pm, Mr Joshua Jenkins, a friend of Ms Saunders', provided her with some basic instructions about riding a Kawasaki KLC 125cc motor cycle including the levers, gears etc.[21] A short time later Ms Saunders put on a helmet and rode off slowly on the motorbike down the paddock. Ms Saunders rode towards the north boundary fence of the property. Mr Jenkins saw Ms Saunders turn right and head east, towards a creek. When Ms Saunders went down the creek embankment, Mr Jenkins lost sight of her. On becoming concerned, he hopped on another motor cycle and headed towards the creek. Within about 20 seconds Mr

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[17] *Commotio cordis* is latin for 'agitation of the heart'. It is a sudden cardiac death that is caused by a blunt forceful trauma in the chest wall. By definition it is blunt trauma to the chest wall in the area of the cardiac silhouette causing ventricular fibrillation (**VF**). Ventricular fibrillation is when the heart quivers instead of pumping due to disorganised electrical activity of the ventricles of the heart. It is a type of cardiac arrhythmia and results in cardiac arrest with loss of consciousness and no pulse.

[18] The property was a 12-acre block that had three sheds and three caravans set up on it. The land itself consisted of some relatively flat ground with a creek running north through it. To the east of the creek, the ground was hilly.

[19] Coronial Brief of Evidence, Statement of Joshua Jenkins dated 1 July 2017.

[20] Coronial Brief of Evidence, Statement of Ms Jessica Sayers dated 1 July 2017.

[21] Coronial Brief of Evidence, Statement of Joshua Jenkins dated 1 July 2017.

Jenkins saw that Ms Saunders was laying in the creek bed in the water with her face partly submerged; the motor cycle on top of her. Mr Jenkins immediately pulled the motor cycle off Ms Saunders and dragged her up the bank. On taking off her helmet, Mr Jenkins saw that Ms Saunders was unresponsive. Within seconds other members of the group arrived at the scene and someone called emergency services. Compliant with instructions from the telephone operator those present commenced CPR on Ms Saunders which was continued until ambulance paramedics arrived. CPR was continued, and treatment given, without success. The paramedics declared Ms Saunders deceased at 3.00pm

20. At the time of the incident visibility was good, with the weather being clear and sunny.[22] The ground was dry; however, the grass was wet from fog and morning dew.[23]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

21. A Coronial Brief was prepared by Leading Senior Constable (**LSC**) Murray Moser. It did not identify any suspicious circumstances surrounding Ms Saunders' death.

22. LSC Moser, an experienced off-road motor cycle rider himself, stated from review of the scene that it appears that Ms Saunders rode east across the paddock where she approached the creek. She then rode over a crest into the bank of the creek before it is assumed that she braked; leaving a skid mark approximately four metres long before rolling off a sharp embankment into the creek and fell off the motor cycle.[24]

23. On inspection of the motor cycle, LSC Moser reported that it was in good condition. The tires were fairly new and had plenty of tread. Everything on the motor cycle was intact and in good condition except for the front brake lever which appeared to have broken off as a result of the crash. When inspected by police the motor cycle was in second gear.

24. LSC Moser stated that in his opinion because Ms Saunders was inexperienced in riding motor cycles she was slow to react when she found the motor cycle going towards the creek. The evidence suggests that Ms Saunders was not travelling very fast when she fell off and it appears that as a result of crashing the motor bike Ms Saunders was thrown forward with chest possibly hitting the handlebars before falling off and onto the ground with the with the motor cycle falling on top of her.

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[22] Coronial Brief of Evidence, Traffic Incident System Report dated 1 July 2017.
[23] Coronial Brief of Evidence, Statement of Joshua Jenkins dated 1 July 2017.
[24] Coronial Brief of Evidence, Statement of Leading Senior Constable Murray Moser dated 30 January 2018.

25. I asked the Coroners Prevention Unit[25] (**CPU**) to provide statistics regarding deaths of off-road motorcycle riders, both on private and public property, and the number who sustained chest trauma, for the past 10 years.[26] The CPU advised Ms Saunders' motorcycle accident was one of 33 reported deaths[27] involving off-road motorcycle riders occurring on public or private property. Of these deaths, nine riders sustained chest trauma, two of which occurred on private property. In a further death, the medical examiner's report identified that chest trauma occurred due to CPR.

RECOMMENDATIONS

26. Pursuant to section 72(2) of the Act and with a view to improve public health and safety, **I recommend that**:

1. The Department of Health and Human Services consider including in the next iteration of the 'State Public Health and Wellbeing Plan' (to be released in September 2019) under the priority of 'Preventing violence and injury', an action to develop and launch a public awareness campaign aimed at off-road motorcycle riders regarding the importance of wearing appropriate chest protection.

2. Alternatively, the Department of Health and Human Services consider actioning the public awareness campaign referred to in Recommendation 1 through the 'Victorian Injury Prevention Program'.

FINDINGS AND CONCLUSION

27. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Emma Louise Saunders, born 7 March 1995;

    (b) Ms Saunders' death occurred:

        (i) at 3.00pm on 1 July 2017, at 25 Wappan Court, Bonnie Doon, Victoria;

        (ii) from a ruptured myocardium in motor cycle incident; and

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[25] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with expert assistance.

[26] The investigation included any death that was reported to the Coroners Court of Victoria where the incident occurred between 1 January 2009 and 26 February 2019.

[27] Deaths that have been reported to the Coroner's Court in accordance with section 4 of the *Coroners Act 2008*.

(iii) in the circumstances described in paragraphs 17 - 20 above.

28. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

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

(a) Mr Rafferty Visser, Senior Next of Kin;

(b) Mrs Michelle Saunders, Next of Kin;

(c) The Department of Health and Human Services; and

(d) Leading Senior Constable Murray Moser, Mansfield Police Station, Coroner's Investigator.

Signature:

DARREN J BRACKEN
CORONER
Date: 20 June 2019