IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5717

**FINDING INTO DEATH WITHOUT INQUEST**

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

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| Findings of: | Simon McGregor, Coroner |
| Deceased: | **Sarah Rose Crimmins** |
| Date of birth: | 1 January 2001 |
| Date of death: | 11 November 2017 |
| Cause of death: | Head injuries sustained in a motor vehicle incident (passenger) |
| Place of death: | Along Frys Road, Gellibrand Victoria 3239 |

## INTRODUCTION

1. Sarah Rose Crimmins was a 16-year-old young person who lived with her family at 45 Corymbia Circuit, Barwon Heads Victoria 3227 at the time of her death.

2. Ms Crimmins died from head injuries sustained in a motor vehicle incident (passenger) along Frys Road, Gellibrand Victoria 3239 on 11 November 2017.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Crimmins' death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008*.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. 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.

6. The Coroner's Investigator, Detective Senior Constable Caitlin Ryan prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, friends, the forensic pathologist who examined Mr Crimmins and investigating officers.

7. 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. 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.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is 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

9. In considering the issues associated with this finding, I have been mindful of Mr Crimmins' basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

## BACKGROUND

10. On the evening of 10 November 2017, Sarah spent the night with her older sister, Louise Crimmins, and Louise's boyfriend, Liam Davis. They travelled to Marcus Wirtanen and Emily Roberts' residence for a bonfire. Liam drove the group to the residence in his 1995 Nissan Patrol Wagon[2] (**vehicle**), arriving just before 9.00pm.[3]

11. The following morning, 11 November 2017, Sarah, Louise and Liam went 'four wheel driving' with their friends, Marcus, Emily and Jack Hudson at Anglesea.[4] The group left at approximately 9.30am and arrived at Anglesea sometime between 10.30am and 11.00am.[5]

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. At some point during the same afternoon, the group decided to drive to Dandos Campground in 'the Otways[6] to check out some of the tracks there'.[7] Along the way, they stopped for ice cream. After getting back in the vehicle and continuing on their journey, Liam told Louise that the brake on his vehicle 'felt funny or was making a funny noise'. Liam took the vehicle to Wonkey Stables Holiday Park in Forest.[8]

13. Liam told Marcus and Jack about his brake.[9] Specifically, that he had heard a thud from his vehicle and knew it came from the brakes.[10]

14. Marcus, who was an apprentice mechanic at the time,[11] had a look at the driver's side front wheel and saw that the brake calliper had shifted from where it was supposed to be at the top

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of Detective Sergeant Janelle Mehegan dated 17 November 2017; VicRoads- Certificate as to registration in certain name, Coronial Brief.

[3] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.

[4] Ibid.

[5] Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.

[6] Otway Ranges is a national park in southern Victoria.

[7] Statement of Louise Crimmins dated 20 November 2017; Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.

[8] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.

[9] Ibid.

[10] Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.

[11] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.

of the rotor disc. It should have been at 'about 9 o'clock but was now at 12 o'clock on the disk'. Marcus could see that the bolts holding the calliper in place were gone.[12]

15. Marcus took the wheel off to gain access. He cut the brake line going to the affected calliper band and put a 'tech screw' in the hose to block and keep oil pressure to the other three wheel's brake callipers. He also put a cable tie around the hose where the tech screw was placed as a secondary measure. He then folded the hose over and clamped it with another cable tie.[13]

16. Marcus told Liam to 'pump the brake pedal countless times' to make sure there was no leak. There was no leak.[14] Liam drove the vehicle back and forth and the brakes worked.[15] Marcus states that he told Liam that with no brake to the front right, his vehicle would pull to the left.[16] Liam understood this.[17] Liam, Marcus and Jack discussed whether it 'was okay to keep going'.[18]

17. At approximately 2.00pm, the wheel was placed back on the vehicle[19] and the group continued on their way. The two vehicles were communicating with each other via 'UHF radio'. Marcus drove ahead and states that he 'would tell Liam if we came across a sharp bend in the road or anything that he should be aware of... I kept telling him to look out for bends and to watch his speed...' as they drove along Frys Road'. The road was slippery because it is a gravel road.[20] For the majority of the journey, Liam was driving in between second and third gear and not exceeding 40 kilometres an hour.[21]

18. The group drove along 'a little track' that was muddy. Marcus' vehicle got bogged, resulting in Liam having to use his vehicle and a winch cable to try and un-bog Marcus' vehicle.[22] Louise and Sarah got out of the vehicle while this was occurring.

19. Once back in the vehicle, Louise told Sarah to put her seatbelt back on. Louise states that she definitely had her seatbelt on because she had to loosen it every time she turned to speak

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[12] Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.
[13] Ibid.
[14] Ibid.
[15] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[16] Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.
[21] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[22] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW; Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.

to Sara, who was sitting in the back seat behind her. Louise states that Sarah was wearing her seatbelt 'properly'. Louise further states that she 'wasn't really concentrating and paying 100% attention to Liam's driving' but that it felt to her as though the vehicle was braking normally and Liam was 'driving normal'.[23]

20. As Liam was driving down Frys Road, the vehicle proceeded around a turn on a decline. The gravel was soft. Liam noticed that his speed had increased to approximately 50 kilometres and put the brakes on. At his Victoria Police interview, Liam stated that the brakes did not work and the vehicle veered towards the ditch on the left, while the back 'went the other way'.[24]

21. Louise was turned around and speaking to Sarah when she felt the vehicle start to skid.[25] The vehicle turned 'fully sideways' but continued to move forwards. The vehicle then 'went up the cliff' to the left before rolling.[26] Louise states that the vehicle sounded 'like it hit something' before she felt it 'spin'. She further states that she remembers having her back against the open window and her back scraping against the ground.[27]

22. 'Once the car stopped rolling… it was just on its side. It was so that the passenger side was on the ground and the driver side was facing up.' Louise and Liam found Sarah partially under the passenger side of the vehicle. Louise and Liam tried to lift the vehicle and attempted to slide Sarah out. Louise attempted cardiopulmonary resuscitation (CPR) before flagging down a passing vehicle.[28]

23. Raedelle Savi was the driver of this vehicle. Also driving with Ms Savi was her son, Zachary Kerr and her friend, Sarah Potter. Ms Savi states that she saw Liam's vehicle on its side and Sarah still partially pinned under the vehicle. Ms Savi stopped her vehicle and the occupants got out.[29] Ms Potter called emergency services at 2.26pm and commenced CPR before Mr Kerr took over.[30] Mr Kerr slid Sarah out enough from under the vehicle so that there was full access to her torso.[31]

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[23] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.
[24] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[25] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.
[26] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[27] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.
[28] Ibid.
[29] Statement of Raedelle Savi dated 11 January 2018, Coronial Brief.
[30] Statement of Sarah Potter dated 30 November 2017, Coronial Brief.
[31] Statement of Raedelle Savi dated 11 January 2018, Coronial Brief.

24. Liam told Ms Savi that he had been travelling at 40 kilometres an hour and had slammed the brakes on. Other people attended and rendered assistance.[32]

25. Marcus' vehicle was ahead of Liam's and had not been in view at the time of the incident. When Liam did not respond to his attempt at contact via the UHF radio, Marcus doubled back along Frys Road. As they drove around a bend, Liam's upturned vehicle came into view. Marcus got out of his vehicle and attempted to render assistance. He asked Liam if Sarah had been wearing her seatbelt. Liam shook his head.[33]

26. Emily called emergency services at 2.28pm.[34] Victoria Police and a single paramedic arrived at approximately 2.46pm. The paramedic attached the defibrillator while CPR was continued.[35]

27. Resuscitation efforts failed and Sarah was declared deceased a short time later.[36]

**Was Sarah wearing a seatbelt?**

28. During his Victoria Police interview, Liam stated that he could not be 100 percent sure that Sarah was wearing her seatbelt. When questioned whether she usually wore her seatbelt, Liam replied, 'usually'.[37]

29. Louise states that every time they got in the vehicle, she told Sarah to put her seatbelt on.[38] This is corroborated by Liam during his Victoria Police interview.[39] After 'winching' Marcus' vehicle, she and Sarah got back into Liam's vehicle. Sarah got into the passenger seat behind Louise. Louise states that she saw Sarah wearing her seatbelt and that she was wearing it 'properly'.[40]

[32] Ibid.
[33] Statement of Marcus Wirtanen dated 11 November 2017, Coronial Brief.
[34] Statement of Emily Roberts dated 11 November 2017, Coronial Brief.
[35] Statement of Senior Constable Tessa McManus 23 March 2018, Coronial Brief.
[36] Statement of Senior Constable Tessa McManus 23 March 2018, Coronial Brief.
[37] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[38] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.
[39] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.
[40] Statement of Louise Crimmins dated 20 November 2017, Coronial Brief.

**Victoria Police Investigation**

30. Detective Sergeant Janelle Mehegan of the Collision Reconstruction and Mechanical Investigation Unit (**the Unit**) attended the scene on the same day of the incident at approximately 7.30pm. She prepared a report dated 17 November 2017.[41]

31. Frys Road, Gellibrand is a two way, single lane road with provision for vehicles to drive in both directions. The road is a gravel road deemed to be in good condition, with no obvious rutting or potholes in the area of the collision. There are no road markings or centre delineation however, the road is wide enough for opposing vehicles to pass each other safely.[42]

32. The road has a significant west bound downhill gradient and a negative cross fall from north to south. The gravel area of the road is approximately 6.85 metres wide. The edges of both sides of the road are denoted by grassed shoulders with a raised embankment on the south side of the road and a gentle sloped shoulder on the north side of the road. The area is classified as rural and has a default speed limit of 100 kilometres an hour.[43]

33. Detective Sergeant Mehegan states that due 'to the gravel surface, steep declines and inclines and tight curves along the road length, vehicles would be unlikely to travel the road at 100km/h'.[44]

34. On the day of the incident, the weather was fine, the road was dry and traffic was light.[45] Results of the preliminary breathe test on Liam returned a negative reading.[46] Liam was taken to Colac Hospital, where he provided a blood sample. He had not consumed drugs or alcohol on the day of the incident.[47]

35. Detective Sergeant Mehegan concluded that in her opinion, the vehicle was travelling west on Frys Road, Gellibrand, towards Main Road. The vehicle was on a steep downhill and in a left curve, when Liam has applied braking sufficient enough to cause the tyres to slide. The vehicle skidded for about 15.1 metres before rotating in an anticlockwise direction towards

[41] Statement of Detective Sergeant Janelle Mehegan dated 17 November 2017, Coronial Brief.
[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] Ibid.
[46] Statement of Senior Constable Tessa McManus 23 March 2018, Coronial Brief.
[47] Victoria Police recorded interview with Liam Davis, WCC 2508/17 AMW, Coronial Brief.

the embankment on the south side of the road. The vehicle continued off the road and into the embankment before it rolled onto the driver's side.[48]

36. She further states that when the vehicle first commenced to skid, she calculates that it was travelling at a minimum speed of 57 kilometres an hour. The anticlockwise rotation with the vehicle having pulled to the left is consistent with the lack of braking on the front driver side of the vehicle.

37. On 14 November 2017, motor mechanic, Acting Sergeant Matthew Craine of the Unit inspected the vehicle and provided a report dated 30 January 2018.[49] In this report, Acting Sergeant Craine details several issues he identified with the vehicle.

38. The aftermarket front suspension springs in the vehicle gave it a higher ride height of approximately 78 millimetres. The bull bar that was fitted would have compressed the springs further towards the maximum allowable vehicle ride height adjustment of 50 millimetres. Due to damage, the exact measurement could not be determined.[50]

39. As the vehicle was 'raised', the handling characteristics were changed. Acting Sergeant Craine states that this would have resulted in the vehicle having a more 'roll on extreme cornering'. The centre of gravity would have been changed. The vehicle was more likely to roll over due to these changes.[51]

40. The rear brakes and passenger side front brake had excellent brake pad thickness and were operational. The driver side rear disc was below minimum thickness and as a result, would have heated up faster than the passenger side rear brake when applied multiple times. This may have caused the brake to be less efficient than that of the passenger rear side, fading earlier under heavy braking. If this occurred, it would have created further imbalances towards the passenger side of the vehicle. Acting Sergeant Craine cannot say with certainty if this occurred.[52] I note that Liam's vehicle had been used in an attempt to winch Marcus' vehicle out of a bog a short time prior to the incident.

41. The brake system was not operating efficiently or safely with the driver side front brake calliper missing from the vehicle. Specifically, the vehicle would have pulled/ steered

[48] Statement of Detective Sergeant Janelle Mehegan dated 17 November 2017, Coronial Brief.
[49] Statement of Acting Sergeant Matthew Craine dated 30 January 2018, Coronial Brief.
[50] Ibid.
[51] Ibid.
[52] Ibid.

toward the left when the brakes were applied, making the vehicle difficult to control. This would have caused or contributed to the incident.[53]

42. Acting Sergeant Craine states that there was no conclusive evidence to confirm or deny if anyone was wearing seatbelts at the time of the incident.[54]

## IDENTITY AND CAUSE OF DEATH

43. On 11 November 2017, Louise Crimmins visually identified the body of her sister, Sarah Rose Crimmins, born 1 January 2001. Identity is not in dispute and requires no further investigation.

44. On 13 November 2017, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Ms Crimmins' body and reviewed a post mortem computed tomography (CT scan) and the Police Report of Death for the Coroner. Dr Young provided a written report, dated 23 November 2017, in which he formulated the cause of death as '*I(a) Head injuries sustained in a motor vehicle incident (passenger)*'.

45. Toxicological analysis of post mortem samples taken from Ms Crimmins did not identify the presence of alcohol, common drugs or poisons.

46. Dr Young commented that review of Ms Crimmins' body and post mortem CT scan did not show any injury which would be unequivocally interpreted as a 'seatbelt' injury. He further details that it is important that the absence of an injury does not mean a seatbelt was not worn.

47. I accept Dr Young's opinion as to cause of death.

## COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

48. I note that on 22 May 2019, Mr Davis was convicted of 'drive in a manner dangerous causing death' and sentenced to serve a Community Corrections Order for a period of three years, commencing 22 May 2019.

49. Section 13 of the *Road Management Act 2004* (Vic) (**the Act**) details that a State road authority may determine speed limits for vehicles on a roadway.

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[53] Ibid.
[54] Ibid.

50. VicRoads details that speed limit signs are not displayed on all Victorian roads. Where signs are not displayed, a default speed is always in effect. 'In rural Victoria, the default speed limit outside of built-up areas is 100 km/h. The default speed limit operates on roads where there are no speed limit signs.'[55] As already discussed, this is the current default limit for Frys Road, Gellibrand Victoria 3239.

## RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

51. I recommend that VicRoads review the default speed limit along Frys Road, Gellibrand Victoria 3239 in the general area of the incident and apply a sign posted limit of 50 kilometres an hour.

## FINDINGS AND CONCLUSION

52. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

53. I express my sincere condolences to Ms Crimmins' family for their loss.

54. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Sarah Rose Crimmins, born 1 January 2001;

    (b) The death occurred on 11 November 2017 along Frys Road, Gellibrand Victoria 3239 from head injuries sustained in a motor vehicle incident (passenger); and

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

[55] https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/a-to-z-of-road-rules/speed-limits

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

(a) Janine Crimmins, senior next of kin

(b) Graham Crimmins, senior next of kin

(c) Ms Sarah Elseidy, Slater and Gordon on behalf of Graham Crimmins, interested party

(d) Ms Abbey Dempster, Transport and Accident Commission, interested party

(e) Ms Sarah Ricketts, Transport and Accident Commission, interested party

(f) Mr Michael Kyriakakis, VicRoads, interested party

(g) Detective Senior Constable Caitlin Ryan, Coroner's Investigator

Signature:


**SIMON McGREGOR**

**CORONER**

Date: 9 December 2019