IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5792

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Acting State Coroner
Deceased:	Jayden Kyle Morgan
Date of birth:	27 June 1997
Date of death:	18 November 2018
Cause of death:	1(a) Traumatic brain injury sustained in a motor vehicle incident (pedestrian)
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria

HER HONOUR:

Background

1. Jayden Kyle Morgan was born on 27 June 1997. He was 21 years old when he died on 18 November 2018 from injuries sustained when he was struck by a car.

2. Mr Morgan lived in Pearcedale with his mother and sister.

3. He was employed as an apprentice plumber – a job that he loved – and worked part-time at Bunnings. His mother described him as a larrikin; he was always happy and joking. He was evidently well-loved, with a large circle of friends from work, school, and football.

4. Mr Morgan's mother noted that he liked to have a social drink with his friends, but this only occurred on weekends. He occasionally became intoxicated when he drank alcohol in a group environment.

The coronial investigation

5. Mr Morgan'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.

6. 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]

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

8. 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

[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.

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

9. Coroner Rosemary Carlin initially had carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Morgan's death. The Coroner's Investigator investigated the matter on Coroner Carlin's behalf and submitted a coronial brief of evidence.

10. After considering all the material obtained during the coronial investigation, Coroner Carlin determined that she had sufficient information to complete her task as coroner and that further investigation was not required.

11. In September 2019, Coroner Carlin was appointed to the County Court and I took over carriage of this matter for the purposes of finalising this finding.

12. 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

13. Mr Morgan was visually identified by his mother, Leanne Morgan, on 18 November 2018. Identity was not in issue and required no further investigation.

Medical cause of death

14. On 20 November 2018, Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Morgan's body and reviewed a post mortem computed tomography (CT) scan.

15. The autopsy revealed severe traumatic head injury and other injuries.

16. Toxicological analysis of post mortem specimens taken from Mr Morgan identified ethanol (0.21 g/100mL), a cocaine metabolite, atropine, and ketamine. Dr Baber noted that a blood alcohol concentration in excess of 0.15% can cause considerable depression of the central nervous system affecting cognition and capable of producing adverse behavioural changes.

17. Atropine and ketamine are likely to have been administered by medical personnel.

18. After reviewing toxicology results, Dr Baber completed a report, dated 18 March 2019, in which she formulated the cause of death as "*1(a) Traumatic brain injury sustained in a motor vehicle incident (pedestrian)*". I accept Dr Baber's opinion as to the medical cause of death.

Circumstances in which the death occurred

19. On the evening of 17 November 2018, Mr Morgan attended a friend's birthday party at a house on Pearcedale Road, Cranbourne South. At the party, he socialised with his friends, played beer pong, and consumed alcoholic drinks.

20. Mr Morgan was due to start work at 7.00am the next morning. As such, he left the party early at 10.30pm and began walking south along Pearcedale Road, Cranbourne South, towards his home in Pearcedale.

21. At 10.48pm, Mr Morgan booked an Uber to pick him up from 226 Pearcedale Road, which was down the road from the house party he had just left.

22. He continued walking south along the northbound lane of Pearcedale Road.

23. At this location, Pearcedale Road is a straight single lane bitumen road with one lane for vehicles travelling south and one lane for vehicles travelling north. The speed limit for this section of Pearcedale Road is 80 kilometres per hour with signs erected. The southbound lane is 3.1 metres wide with a 1.4-metre-wide bitumen shoulder. Beside the shoulder on the northbound lane is a shallow gravel drain. Beside the drain is a grassed embankment with trees.

24. Along this section of Pearcedale Road, there are no footpaths for pedestrians to walk along – the only area available for pedestrians is the shoulder of the roadway. There are no streetlights. The area is semi-rural with a mix of large residential and farming properties.

25. At that time of night, there was little traffic on the road. The road was dry and the weather fine.

26. Mr Morgan's mother stated that her son was very familiar with this part of Pearcedale Road as he used it almost every day.

27. At approximately 10.57pm, a Toyota Prado Wagon drove towards Mr Morgan. It is believed that Mr Morgan presumed that this was his Uber ride. Mr Morgan subsequently stepped out onto the roadway and into the path of the oncoming Toyota, likely in an attempt to flag it down.

28. The Toyota subsequently collided with Mr Morgan, which caused him to suffer significant injuries.

29. The driver of the Toyota stated that as he drove north along Pearcedale Road, he began to decrease his speed as the speed limit was due to change from 80 kilometres per hour to 60 kilometres per hour. He subsequently saw an object in the left corner of his eye and recognised it was a person running across towards the front of his car. The driver turned the steering wheel to the right as quickly as he could but could not avoid colliding with Mr Morgan, who impacted the front passenger headlight area and the front passenger side windscreen area of the vehicle.

30. The driver immediately stopped and rendered assistance, along with other passers-by. Emergency services were contacted, and an ambulance arrived approximately five minutes later.

31. Mr Morgan was subsequently airlifted to Royal Melbourne Hospital. Despite treatment, Mr Morgan was asystole for 20 minutes and the treating team concluded that his injuries were unsurvivable. He was pronounced deceased at 1.20am on 18 November 2018.

32. A Victoria Police inspection of the Toyota did not reveal any faults that would have caused or contributed to the collision.

33. A Victoria Police reconstruction of the collision determined that the Toyota was likely travelling between 57 and 65 kilometres per hour at the time of the collision.

34. Leading Senior Constable Paul Hughes's summary of the collision noted that it was very dark at the time of the collision with limited visibility. Mr Morgan was wearing dark clothing and would not have been seen clearly by the approaching Toyota before he stepped out in front of it. I note that the driver of the Toyota has not been charged with any offences connected to the collision.

35. I also note that Mr Morgan's mother described Pearcedale Road as extremely dangerous at night as there is no streetlighting and no footpath for pedestrians. The driver of the Toyota noted that if there were streetlights, he may have seen Mr Morgan sooner and the collision may not have occurred.

Findings

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

(a) the identity of the deceased was Jayden Kyle Morgan, born 27 June 1997;

(b) Mr Morgan died on 18 November 2018 at Royal Melbourne Hospital, 300 Grattan St, Parkville, Victoria, from traumatic brain injury sustained in a motor vehicle incident (pedestrian); and

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

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. That Casey City Council consider installing streetlighting and pedestrian footpaths at the location at which the collision occurred.

2. That VicRoads consider reducing the speed limit on Pearcedale Road, Cranbourne South, given the lack of streetlighting and safe pedestrian access.

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 Mr Morgan's family.

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

Leanne Morgan, Senior Next of Kin
Royal Melbourne Hospital
Leading Senior Constable Paul Hughes, Coroner's Investigator, Victoria Police

Signature:

CAITLIN ENGLISH
ACTING STATE CORONER
Date: 12 November 2019