



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0849

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	MICHELLE HODGSON, CORONER
Deceased:	SAMUEL ALEXANDER CHILTON
Date of birth:	31 March 2003
Date of death:	14 February 2019
Cause of death:	1(a) Multiple injuries in the setting of a truck incident (cyclist)
Place of death:	Ziegler Parade/Princess Highway Junction Allansford, Victoria 3277

HER HONOUR:

Background

1. Samuel Alexander Chilton was born on 31 March 2003. He was 15 years old at the time of his death and was the loved son of Neil and Tracy Chilton. He lived with his parents in Allansford.
2. Samuel's father described him as a sociable person who had a keen interest in playing sports and competitive motorbike riding. He was in grade 10 and studied Vocational Education Training in building.
3. According to his father, Samuel rode a bicycle all his life. He would ride from home to the Allansford town centre to attend football or cricket training. To reach Allansford town centre Samuel had to cross the Princes Highway.
4. To lawfully reach the town centre from the Princes Highway, a cyclist must ride eastbound along the highway and merge into a dedicated right-hand turning lane to enter Garabaldi Lane. Garabaldi Lane then intersects with Zeigler Parade, which runs into the town centre to the east. Taking this course is a difficult and potentially dangerous task for cyclists, as it involves riding amongst fast-moving highway traffic including heavy vehicles.
5. Ziegler Parade connects with the Princes Highway to the west by way of a one-way road which merges with the southbound lane of highway traffic. It displays a 'No Entry' sign to traffic on the Princes Highway.
6. Samuel's father stated that Samuel ordinarily crossed the highway near Allansford-Wangoom Road, before the Ziegler Parade merging lane. He would then ride along the inside of the merging lane, against the flow of traffic, and onto Ziegler Parade in the wrong direction. Samuel would then cross a bridge on Ziegler Parade by way of a pedestrian crossing and have access to bike lanes which then run the length of the road.
7. According to Mr Chilton, local residents have felt it is safer to cross the highway and travel down Ziegler parade in the wrong direction than travel further down the Princes Highway.

The coronial investigation

8. Samuel's death was appropriately reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.
9. 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
10. The law is clear that coroners establish facts; they do not cast blame or determine criminal or civil liability.
11. 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.
12. Victoria Police assigned Senior Constable Peter Hunter (**SC Hunter**) to be the Coroner's Investigator in Samuel's death. SC Hunter investigated the matter on my behalf and submitted a coronial brief of evidence which contained statements from witnesses and Samuel's parents, among other relevant documents.
13. In view of concerns raised by Mr Chilton regarding cyclist safety while crossing the Princess Highway to reach Allansford, I requested the Coroners Prevention Unit² (CPU) review the circumstances of Samuel's death and provide advice on opportunities to prevent similar deaths in future.

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.

² The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists coroners to formulate prevention recommendations and comments and monitors and evaluates their effectiveness once published.

14. 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.
15. 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

16. On 14 February 2019, Samuel Alexander Chilton was visually identified by his father, Neil Chilton. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. On 15 February 2019, Dr Melanie Archer, Forensic Pathology Registrar at the Victorian Institute of Forensic Medicine (the VIFM) conducted an external examination upon the body of Samuel and reviewed a post mortem computed tomography (CT) scan.
18. Toxicological analysis of post mortem specimens taken from Samuel did not detect alcohol, common drugs or poisons.
19. Dr Archer completed a report, dated 21 February 2019, in which she formulated the cause of Samuel's death as "*1(a) Multiple injuries in the setting of a truck incident (cyclist)*". I accept Dr Archer's opinion as to the medical cause of death.

Circumstances in which the death occurred

20. On the afternoon of 14 February 2019, Samuel set out from home on his bicycle to attend cricket training in Allansford.
21. At about 4:50pm, Samuel rode his bicycle eastbound along Princes Highway. That section of Princes Highway has a single lane of traffic running in northeast and southwest directions, divided by solid double white lines.
22. As Samuel approached the intersection with Ziegler Parade, which was on the opposite side of the highway, he steered across the westbound lane apparently intending to enter Ziegler Parade.

23. Meanwhile, a cement truck travelled westbound on Princes Highway. In a statement to Police, the driver of the truck stated:

As I approached Ziegler Pde, which merges with the Princes Highway from my left, I observed a cyclist crossing the road of the oncoming traffic. I thought he would stop. Then he kept looking over his left shoulder, he appeared very distracted, he was peddling and kept coming.

24. The driver of the truck braked and steered left to avoid hitting Samuel. A witness who was travelling behind the truck stated: *“I saw then that the cyclist then rode faster, across our lane and tried to cross in front of the truck”*.
25. The truck skidded and rotated as it braked. It collided with the rear of a Toyota Land Cruiser which was travelling down Ziegler Parade and merging onto Princes Highway. The rear of the truck collided with Samuel. The truck rolled onto its side before coming to rest.
26. Witnesses immediately stopped to assist, and Emergency Services were called. Victoria Police, Ambulance Victoria paramedics, and State Emergency Services personnel arrived shortly afterwards. Samuel was pronounced deceased at the scene.
27. Police located Samuel’s mobile phone at the scene, which was playing loud music. Police did not find headphones.
28. At the time of the collision, it was daylight, the road was dry, and conditions were clear. The speed limit at the location of the incident was 100km/h.

Further investigation

Police mechanical investigation

29. Detective Sergeant (DS) Dr Jenelle Catherine Mehegan of the Collision Reconstruction and Mechanical Investigation Unit of Victoria Police provided a comprehensive expert report. DS Dr Mehegan concluded that the truck was travelling at a maximum of 91km/h when the driver commenced braking. DS Dr Mehegan found no evidence that the Toyota was travelling in excess of the speed limit.

According to DS Dr Mehegan, the driver of the truck reacted to the cyclist as expected.

30. Coroners Investigator SC Hunter produced section 84(1) certificates pursuant to the *Road Safety Act 1986*) which indicate that the driver of the truck and the Toyota were both licensed to drive a motor vehicle. Police enquiries indicated that the truck driver had a full and current Victoria heavy motor vehicle licence.
31. A mechanical inspection of the truck and Toyota was not undertaken by the Police Collision Reconstruction and Mechanical Investigation Unit as there was insufficient evidence that mechanical fault contributed to the collision.

Investigation of family concerns

32. Given Mr Chilton's comment that residents who ride to Allansford town centre cross the Princes Highway and access Zeigler Parade as there are no safer options, I requested that the CPU review whether other fatalities have occurred on Princes Highway near the Zeigler Parade ramp.
33. The CPU did not identify any other fatal motor vehicle incidents at this location between 1 January 2000 and 31 July 2019.

Conclusions

34. The evidence supports a finding that Samuel rode into the path of oncoming traffic while crossing the highway and intended to enter Zeigler Parade in the wrong direction. I accept Mr Chilton's evidence that taking this route is the practice of Allansford residents. Cyclists must obey the road rules.
35. There is no evidence to suggest that driver fault including alcohol or drug use, excessive speed, fatigue, driver behaviour, vehicle condition, or mobile phone use were contributing factors to the incident, and I am satisfied that the truck driver had no reasonable opportunity to avoid the collision.
36. In all the circumstances, I consider it most likely that Samuel rode into the path of oncoming traffic as a result of an error of judgement or lapse in concentration.

Recommendations

37. Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:
38. With the aim of promoting public health and safety, I recommend that VicRoads and the City of Warrnambool review cycling infrastructure along Princes Highway, Allansford, giving consideration to how cyclists including children cycle along Princes Highway and into Allansford town centre.
39. I recommend that Allansford Football Netball Club and Allansford Cricket Club each publish a notice in their newsletter reminding people who cycle to the Allansford Recreation Reserve not to enter Zeigler Parade via the Princes Highway merging ramp, as doing so is unsafe and does not comply with the road rules.

Findings

40. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Coroners Act 2008 (Vic):
 - (a) the identity of the deceased was Samuel Alexander Chilton born 31 March 2003;
 - (b) Samuel died on 14 February 2019 at Ziegler Parade/Princess Highway Junction, Allansford, Victoria from multiple injuries in the setting of a truck incident (cyclist); and
 - (c) the death occurred in the circumstances described above.
41. I offer my sincere condolences to Samuel's mother Tracy and father Neil, together with his extended family, friends and community.
42. I wish to acknowledge the courage of community members who stopped to assist all involved in the incident including Samuel, who tragically died.
43. Pursuant to section 73(1) of the Act, I direct that a copy of this finding be published on the Coroners Court website.

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

Tracy Chilton, Senior Next of Kin

Neil Chilton, Senior Next of Kin

VicRoads

City of Warrnambool

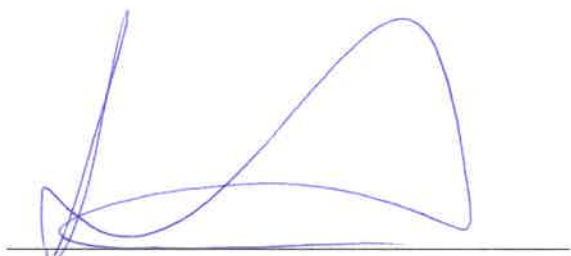
Allansford Football Netball Club

Allansford Cricket Club

Commission for Children and Young People

Senior Constable Peter Hunter, Coroner's Investigator

Signature:



MICHELLE HODGSON

CORONER

Date: 6.1.2020

