IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1003

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Bernice Edna Northover**
Date of birth:	27 August 1929
Date of death:	23 February 2019
Cause of death:	Multiple injuries sustained in a motor vehicle incident (driver)
Place of death:	Intersection of Wellington Road and Berwick Road, Narre Warren East, Victoria 3804

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HIS HONOUR:

BACKGROUND

1. On 23 February 2019, Bernice Edna Northover was 89 years old when she died from injuries sustained after the vehicle she was driving collided with another vehicle at the intersection of Wellington Road and Berwick Road in Narre Warren East, Victoria. Immediately prior to her death, Mrs Northover lived at 2/29 Kent Street, Warragul, Victoria.

2. At the time of her death, Mrs Northover was driving a silver 2002 Holden Astra sedan registered to Mrs Northover who held a current and full Victorian driver's licence.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mrs Northover's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) (Vic) ("the Act"), as his death occurred in Victoria, was unexpected and resulted, directly or indirectly, from an accident or injury.[1]

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

   (a) the identity of the deceased.

   (b) the cause of death and

   (c) the circumstances in which death occurred.[2]

5. For coronial purposes, '*circumstances in which death occurred*'[3] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating 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.

6. The coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

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[1] Section 4 *Coroners Act 2008*.

[2] See Preamble and s 67, *Coroners Act* (2008).

[3] Section 67(1)(c).

[4] *Keown v Khan* (1999) 1 VR 69.

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;[6]

   (b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[7] 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.[8]

9. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[9] 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.[10]

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 demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[11] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13]

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[5] Section 69 (1).
[6] Section 72(1).
[7] Section 67(3).
[8] Section 72(2).
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that 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 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[11] *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.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[13] *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 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.

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 26 February 2019, Mark Northover identified the deceased as his mother, Bernice Edna Northover, born on 27 August 1929.

12. Mrs Northover's identity is not in dispute and requires no further investigation.

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

13. On 25 February 2019, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination upon Mrs Northover's body. Dr Young also reviewed the Police Report of Death (Form 83) and provided a written report, dated 28 February 2019, in which he opined that the cause of Mrs Northover's death was '*multiple injuries sustained in a motor vehicle incident (driver*)'. I accept Dr Young's opinion.

14. Toxicological analysis of post-mortem samples showed the presence of atenolol.[14] Ethanol (alcohol) was not detected.

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

15. On 23 February 2019 at approximately 3.30pm, Mrs Northover was driving east on Wellington Road approaching the intersection of Berwick Road where she intended to turn right. Witness Gayan De Saram, who was driving behind Mrs Northover's vehicle (**the Holden**) elaborated:

> "*I saw the brake lights come on after the silver car entered the turn lane and it seemed to almost come to a brief stop then continued on again as if the driver wasn't sure whether to turn into that that first road or not. I had to also brake when the silver car did this."*[15]

16. Mrs Northover continued driving along the turn lane then stopped at the Berwick Road intersection whilst giving way to west bound vehicles on Wellington Road before

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[14] Atenolol is a β1-antagonist indicated for hypertension, angina, and prevention of cardiac dysrhythmia in myocardial infarction. Atenolol is typically available in 25-100 mg tablets for oral administration or 0.5 mg/mL solutions for intravenous infusion. Oral doses range from 50-100 mg/day, or 5-10 mg intravenously.

[15] Statement of Gayan De Saram dated 5 March 2019; Coronial Brief.

commencing to turn right into Berwick Road across the path of the Mitsubishi Pajero 4WD (**the Pajero**) driven by Charlie Reid-Simmons carrying two passengers.

Mr De Saram said:

> *"All of a sudden I noticed the silver car in front start to gradually move forward and it seemed to just roll forward. This movement caught me by surprise as I could see a car, which was a gold coloured 4WD type vehicle, coming the opposite direction toward the intersection. I couldn't tell you how far away it was in metres or car lengths, only that I knew that there was not enough room or time to turn in front of it."*[16]

17. Mr Reid-Simmons applied emergency braking but was unable to avoid the Holden, and the two vehicles collided with impact to the passenger side of Mrs Northover's vehicle causing the Holden to spin and collide with a stationary Nissan Patrol wagon (**the Nissan**), before coming to rest on the north side of the intersection of Wellington Road and Berwick Road.

18. Witness Rosemary Passmore, who was driving along Wellington Road and about to turn left into Berwick Road said that she was "*concentrating on the approaching intersection as I think it is a fairly dangerous intersection.*"[17] Mrs Passmore elaborated:

> *"I saw the little car across the intersection and then I am pretty sure the car stopped across the intersection. It wasn't like a fluid movement you usually get from someone turning into Berwick Road. As the little car sort of stopped there was an almighty bang and then I saw two cars up in the air, spinning around and car bits going everywhere."*[18]

19. Witness Troy Schetter's vehicle was stationary at the intersection of Wellington Road and Berwick Road when he saw the collision. Mr Schetter said:

> *"Straight away I knew she was going to get hit by the oncoming Pajero. I immediately said to myself what is she doing...she didn't accelerate quickly or attempt to brake at any stage it was just a slow turn and like she was oblivious to the oncoming Pajero."*[19]

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[16] Ibid.
[17] Statement of Rosemary Passmore dated 6 March 2019; Coronial Brief.
[18] Statement of Rosemary Passmore dated 6 March 2019; Coronial Brief.
[19] Statement of Troy Schetter dated 26 February 2019; Coronial Brief.

20. Mr De Saram's wife immediately called emergency services. When Mrs Passmore approached Mrs Northover's vehicle, she observed that Mrs Northover was "*taking shallow irregular breaths*".[20] A short time later, Mrs Northover fell unconscious and became unresponsive. The emergency services operator instructed those present to perform cardiopulmonary resuscitation (**CPR**) on Mrs Northover, which they did until Country Fire Authority (CFA) units arrived and assisted with CPR. Upon arrival, paramedics continued resuscitation efforts.

21. Leading Senior Constable Bruce Dingjan was working with Constable Jess Graham of Belgrave Police the day of the incident. At approximately 3.25pm, they were called to attend the intersection of Wellington Road and Berwick Road in Narre Warren East for a major vehicle collision. At 3.40pm they arrived on the scene. Ambulance Victoria and Country Fire Authority (CFA) units were present. Ambulance paramedics were unable to revive Mrs Northover and she was declared deceased at the scene at 3.51pm.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

22. Police examined the scene on the day of the incident and noted that Mrs Northover's vehicle had significant damage to the passenger side doors and rear. The Pajero had significant damage to the front passenger side of the vehicle and the Nissan had minor damage to the front and driver's side of the vehicle. The tyre skid marks were consistent with the driver of the Pajero having reacted to the Holden turning across its path by applying emergency braking. Mr Reid-Simmons and his two passengers sustained minor injuries and the driver of the Nissan was uninjured.

23. At this location, Wellington Road is a two-way, two lane road that runs generally east to west. At the intersection of Berwick Road, there was an additional right turn lane for vehicles travelling east on Wellington Road to turn right into Berwick Road, and an additional left turn lane for vehicles travelling west on Wellington Road to turn left into Berwick Road. The road is constructed of bitumen and is said have been in excellent condition. East of the intersection the opposing lanes were divided by a painted traffic island. West of the intersection the opposing lanes were divided by the right turn lane. There is a crest east of the intersection. The outer edges of the traveling lanes were denoted by audible tactile strips[21]. There are bitumen shoulders on both the north and south sides of the road;

[20] Statement of Rosemary Passmore dated 6 March 2019; Coronial Brief.

[21] Audible tactile strips cause a tactile vibration and audible rumbling transmitted through the wheels into the vehicle interior.

narrowing at the intersection. The area is considered semi-rural, surrounded by small acreage properties. The speed limit is 80km/h as sign posted. Police observed that at the time of the incident, the weather was fine and the road was dry.[22]

24. On 2 May 2019, Dale Woodland, a qualified motor vehicle mechanic working with Victoria Police Major Collision Investigation Unit (**MCIU**), completed a mechanical examination on Mr Reid-Simmons' vehicle. In his statement dated 26 July 2019, Mr Woodland concluded that his examination did not reveal any mechanical fault or condition with the vehicle which could have caused or contributed to the collision.

25. Dr Jenelle Mehegan of the MCIU reconstructed the collision and provided a statement dated 22 April 2019, in which she concluded that when the two vehicles collided the Pajero was travelling at no less that 69km/h. At the commencement of braking, the Pajero was travelling at no less than 101km/h.

26. In Dr Mehagan's opinion even if Mr Reid-Simmons was travelling at the speed of 80km/h when he applied the brakes, which would have reduced the collision speed from 69km/h to 27km/h (had it still occurred) it could not be safely said that the collision would not still have resulted in Mrs Northover's death. At least a cause, if not the primary cause of the collision appears to be Mrs Northover turning right into Berwick Street when she did. I take into account Dr Mehegan's opinion that at the commencement of braking Mr Reid-Simmons's Pajero was travelling at not less than 101 km/h, some 21 km/h in excess of the applicable speed limit. It may be that Mrs Northover did not clearly appreciate the speed of Mr Reid-Simmons' Pajero as she considered whether it was safe to turn into Berwick Street so that Mr Reid-Simmons' speed was also a cause of the collision. It is at the very least likely that Mrs Northover would not have commenced the turn if she did not think that she could complete it safely. The speed of Mr Reid-Simmons' Pajero before it commenced braking may have been another cause of the collision, however the evidence does not allow me to make a such a finding.

27. The coronial brief refers to Police having assessed the road environs in the vicinity of Mrs Northover's death, and in concluding that it is an accident blackspot, the road safety management ought to be addressed. The brief also contains non-specific reference to

[22] Statement of Dr Jenelle Catherine Mehegan dated 22 April 2019; Coronial Brief.

twenty-eight separate reported collisions having occurred at the intersection of Mrs Northover's death between December 2014 and March 2019.[23]

28. On 29 October 2019 at the Melbourne Magistrates Court, Mr Reid-Simmons plead guilty to one count of '*reckless driving*' in relation to his involvement in the collision that killed Mrs Northover. Mr Reid-Simmons was convicted and fined $600, and his licence was suspended for six months from 25 July 2019.

29. I am satisfied, having considered all of the available evidence, that no further investigation into Mrs Northover's death is required.

The Intersection

30. In 2018, VicRoads Project Development team completed investigations at the site and met with the Safe System Road Infrastructure Program (**SSRIP**) in June 2018 with a proposal to implement a conventional roundabout at the site. However, due to the high cost estimate, SSRIP were unable to fund the volume of work required. According to Senior Traffic Engineer at the Department of Transport, Darren Yang, discussions were subsequently held around adopting an innovative roundabout treatment option, however, VicRoads was not comfortable prioritising an innovative non-standard treatment at such a high speed and/or risk site. This, coupled with the reasonably high cost of the project led to a follow up commitment by the region to investigate a signalised option. On 24 January 2020, the intersection was flagged again for SSRIP to include the site in the next round of Transport Accident Commission (TAC) funding.[24]

Recommendations

Recommendation Number 1.

31. I recommend that, VicRoads immediately install 'road infrastructure'[25] at the intersection of Wellington and Berwick Roads Narre Warren so as to substantially increase the safety of that intersection for all road users.

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[23] Correspondence of DLSC Matthew Hunt dated 10 February 2020; Coronial Brief.

[24] Correspondence of Snr Traffic Engineer, Darren Yang dated 11 February 2020; Coronial Brief.

[25] Whether that infrastructure consists of signs or warning signals of some kind or something else is a matter for VicRoads.

Recommendation Number 2.

32. I recommend that VicRoads immediately undertake an urgent comprehensive assessment of the condition, design and function of the intersection of Wellington Road and Berwick Road, Narre Warren East with a view to urgently making changes to increase its safety for all road users. I further recommend that as soon as is practicable VicRoads implement the findings of the review and that the measures put in place as a result of recommendation number 1 remain in place until the findings of the review are implemented.

FINDINGS AND CONCLUSION

33. 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 Bernice Edna Northover, born 27 August 1929;

    (b) Mrs Northover's death occurred;

        i. on 23 February 2019 at the intersection of Wellington Road and Berwick Road, Narre Warren East, Victoria 3804;

        ii. from multiple injuries sustained in a motor vehicle incident (driver); and

        iii. in the circumstances described in paragraphs 15 – 21 above.

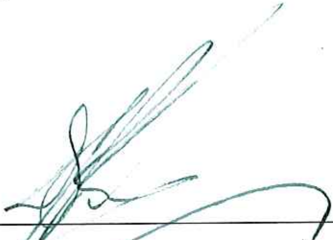
34. I direct that a copy of this finding be provided to the following:

   (a) Mr Peter Northover, senior next of kin.

   (b) Mr Paul Northey, Chief Regional Roads Officer, VicRoads.

   (c) Detective Leading Senior Constable Matthew Hunt, Coroner's Investigator, Victoria Police.

Signature:



DARREN J BRACKEN

CORONER

Date: 29 June 2020.