IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2161

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Gregory Mark Hulands**
Date of birth:	26 May 1965
Date of death:	29 April 2019
Cause of death:	Mechanical asphyxia in the setting of a motor vehicle incident (driver)
Place of death:	Calder Alternative Highway, Ravenswood, Victoria 3453

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HIS HONOUR:

BACKGROUND

1. On 29 April 2019, Gregory Mark Hulands was 53 years old when he died from injuries sustained after the vehicle he was driving left the Calder Alternative Highway and rolled down the embankment near Fentons Lane in Ravenswood, Victoria. Immediately prior to his death, Mr Hulands lived at 29 O'Connor Street, Nyah West, Victoria.

2. No medical history was obtained during the course of the investigation into Mr Hulands' death.

3. At the time of his death, Mr Hulands was driving a 1994 Kenworth T600 Prime Mover towing a 2011 Freightliner tri-axle trailer. The Prime Mover was registered to DBSA Services Pty Ltd.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Hulands' 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]

5. The Act requires a coroner to investigate reportable deaths such as Mr Hulands' 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]

6. 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.

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[1] Section 4 *Coroners Act 2008*.
[2] See Preamble and s 67, *Coroners Act* (2008).
[3] Section 67(1)(c).

7. 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.

8. 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.

9. 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]

10. 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]

11. 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

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

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]

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

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

12. On 29 April 2019, Dorothy Hulands identified the deceased as her son, Gregory Mark Hulands born on 26 May 1965.

13. Mr Hulands' identity is not in dispute and requires no further investigation.

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

14. On 2 May 2019, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy upon Mr Hulands' body. Dr Young also reviewed the Police Report of Death (Form 83) and provided a written report, dated 30 May 2019, in which he concluded that the cause of Mr Hulands' death was '*mechanical asphyxia in the setting of a motor vehicle incident (driver)*'. I accept Dr Young's opinion.

15. Dr Young commented that the autopsy showed congestion and Tardieu spots[14] on the skin of the upper body, conjunctival haemorrhages in the eyes, a bruise on the underside of the left sternohyoid muscle in the neck. The lungs were heavy and congested. A fracture was seen through the left side of the maxilla (facial bone), which would not have been a fatal injury.

16. Dr Young further commented that traumatic asphyxia and positional asphyxia are both forms of mechanical asphyxia whereby there is positioning of the body (in particular the neck) and mechanical fixation of the chest that restricts inspiration and respiratory movements, thus preventing effective breathing. As a result of the collision the truck's steering wheel came to be resting on Mr Hulands' neck, and his chest was positioned such that his ability to breathe was decreased.

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[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, Brennan Deane and Gaudron JJ.
[14] Tardieu spots are purple to black spots on the skin that can develop along with lividity, from the rupture of capillaries.

17. Toxicological analysis of post-mortem samples showed the presence of delta-9-tetrahydrocannabinol (cannabis) at ~59ng/ml.[15] Ethanol (alcohol) was not detected. Epidemiological studies have shown that recent use of cannabis does increase crash risk when driving motor vehicles (including motorcycles)[16]. This risk starts to become apparent at around 5 ng/mL, however a substantial elevated risk occurs at higher concentrations, possibly at around 10 ng/mL or higher.

18. Dr Young commented that persons under the influence of cannabis may experience impaired cognition, poor vigilance and impaired reaction times and coordination; however, in this case it is not possible to determine how soon prior to death Mr Hulands consumed cannabis.

19. Dr Young noted that the autopsy also showed evidence of heart disease. The left anterior descending and right coronary arteries showed severe atherosclerosis. Whilst there was no significant myocardial fibrosis seen in the left ventricle of the heart, there was marked endocardial fibrosis and transmural fibrofatty change seen in the anterior right ventricle and right ventricular outflow tract. Given the focal nature of this myocardial change, it is unlikely to represent any specific cardiomyopathy. Conversely, in spite of the focal nature, it was not in the typical distribution of any coronary artery. The changes are therefore thought to possibly represent a focus of healed myocarditis.

20. Dr Young further noted that in the absence of any other factors leading to Mr Hulands losing control of the vehicle, resulting in the vehicle leaving the road, it cannot be excluded that Mr Hulands may have had a non-fatal cardiac arrhythmia ("heart attack") in the setting of his severe coronary artery atherosclerosis. However, the autopsy findings are not consistent with Mr Hulands being dead when the truck left the road.

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

21. Police viewed closed-circuit television footage from Pentarch's hay processing and storage facility in Ultima which showed Mr Hulands' vehicle arriving at the premises on 29 April 2019 at 10.20am, and after the vehicle was loaded, leaving the premises at 10.39am.

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[15] Tetrahydrocannabinol (THC) is the active form of cannabis. The strength of cannabis usually varies from 2-4% but can exceed 10%.

[16] Drummer, O.H., et al., The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes. Accident Analysis & Prevention, 2004. 36(2): p. 239-248.

Laumon, B., et al., Cannabis intoxication and fatal road crashes in France: population-based case-control study. BMJ., 2005. 331(7529): p. 1371.

Grotenhermen, F., et al., Developing limits for driving under cannabis. Addiction, 2007. 102(12): p. 1910-7.

22. On that same day at about 12:30pm, Colin Reynolds was driving behind the truck when he observed Mr Hulands' vehicle lean to the left around the roundabout at the intersection of the Calder Alternative Highway and Lockwood Road. Mr Reynolds believed that Mr Hulands, "*might have gone up on the curb on the inside of the roundabout*". As Mr Hulands' vehicle subsequently approached a right-hand sweeping bend, Mr Reynolds observed the truck cross the centre line of the highway and the right-hand tyres of the trailer, "*come off the ground and I saw smoke coming off the trailer tyres on the left-hand side and the black marks on the road.*" The trailer then tracked left before slipping down the embankment which resulted in Mr Hulands' vehicle leaving the Calder Alternative Highway then rolling down the embankment near Fentons Lane in Ravenswood, Victoria. Mr Reynolds immediately called emergency services.

23. Paramedic, Shane Chapman and his wife, who lived on Fentons Lane heard the accident and went to the scene. Mr Chapman saw that Mr Huland was trapped in the cab and his body was pinned by the dash. Mr Hulands was apparently unconscious and he, Mr Chapman managed to check Mr Hulands' pulse which was "*weak and slow and after two minutes it stopped completely*".[17]

24. Senior Constable (**SC**) Paul Schroeder was working with Leading Senior Constable (**LSC**) William Edwards of Maryborough Police the day of the incident. At approximately 1.07pm they were called to attend the Calder Alternative Highway near the intersection of Fentons Lane for a single vehicle collision. At 1.13pm they arrived on the scene. Ambulance Victoria and State Emergency Service (**SES**) units were present. Ambulance paramedics confirmed Mr Hulands was deceased.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

25. Police examined the scene on the day of the incident and noted that Mr Hulands' vehicle had rolled approximately 1.5 metres down an embankment. The prime mover was on its roof and had "*significant damage to the cab area*".[18] The tri-axle trailer and the container appeared to have impacted a tree approximately 10 metres off the east side of the road. The trailer and its contents (compressed hay bales) were strewn around the trailer and the side of the road. A wallet was located containing cards belonging to Mr Hulands.

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[17] Statement of Shane Chapman dated 7 August 2019; Coronial Brief.
[18] Statement of SC Paul Schroeder dated 31 December 2018; Coronial Brief.

26. At this location, Calder Alternative Highway is a rural road that travels from the Calder Freeway Ravenwood to the Calder Freeway Marong, in a north west and south east direction. The road is primarily a bitumen base with a 1.7 metre hard shoulder with a "*further dirt shoulder*".[19] The speed limit for the road is 100km/h. Police observed that at the time of the incident, the weather was fine, and the road was dry and in good repair.

27. Police observed that the stretch of the Calder Alternative Highway where the collision occurred is designed with a sweeping right-hand bend which has a decline and intersecting road (Fentons Lane). The corner does not have any advisory speed signs or physical barriers on the left-hand side of the road. SC Paul Schroeder said:

> "*In my opinion straightening this section of the Calder Alternative Highway to eliminate the preceding sweeping left-hand bend and the right-hand bend would be the best solution to improve the safety of the road. At a minimum the addition of speed advisory signs and roadside physical barriers would assist light and heavy vehicles with negotiating the section of the road and minimise the chance of a vehicle leaving the roadway and rolling down the embankment.*"

28. During the course of the investigation, Shane Chapman told the Coronial Investigator, "*I have lived at the Fentons Lane address [sic] 10 years during that time there have been 3 fatalities and at least another half a dozen accidents on that stretch of the Calder Alternative Hwy*".[20]

29. On 22 October 2019, Senior Constable Raymond Finch, a qualified motor vehicle mechanic working with Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**), completed a mechanical examination on Mr Hulands' vehicle. In his statement dated 5 December 2019, SC Finch concluded that his examination did not reveal any mechanical fault or failures with the vehicle which could have caused or contributed to the collision.

30. I am unable to say precisely what caused Mr Hulands' and his vehicle to leave the road and roll down the embankment, illicit drugs he had ingested may have played a part separately from or together with atherosclerosis. While there is no evidence the vehicle was travelling at an excessive speed, it may have been travelling too fast to negotiate the bend in the road. The vehicle's speed through the bend combined with road design, inappropriate placement of

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[19] Statement of SC Paul Schroeder dated 31 December 2018; Coronial Brief.
[20] Statement of Shane Chapman dated 7 August 2019; Coronial Brief.

vehicle on the road and the high centre of gravity of the vehicle's load may have all contributed to the vehicle leaving the road.

31. The coronial brief refers to Police having assessed the road environs in the vicinity of Mr Hulands' death and concluding that signage and safety barriers ought to be addressed. The brief also contains an unspecific reference to several collisions having occurred near the site of Mr Hulands' death over a period of approximately 10 years.

32. I am satisfied, having considered all of the available evidence, that no further investigation into Mr Hulands' death is required.

Recommendations

33. I recommend that, informed by appropriate input from Victoria Police, VicRoads undertake an assessment of the condition of Calder Alternative highway near Fentons Lane, Ravenswood including the adequacy of signage and road safety barriers applicable to traffic travelling in a north west and south east direction. I further recommend that VicRoads make any necessary changes to signage and road safety barriers that this review identifies as being desirable.

FINDINGS AND CONCLUSION

34. 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 Gregory Mark Hulands, born 26 May 1965;

    (b) Mr Hulands' death occurred;

        i. on 29 April 2019 at Calder Alternative Highway, Ravenswood, Victoria 3453;

        ii. from mechanical asphyxia in the setting of a motor vehicle incident (driver); and

        iii. in the circumstances described above.

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

(a) Mrs Carole Hulands, senior next of kin.

(b) Mr Robert Shepard, Wisewould Mahoney.

(c) VicRoads.

(d) Senior Constable Paul Schroeder, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 24 June 2020