IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1356

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**VLADIMIR MARK MAKOVNIK**
Date of birth:	**20 January 1990**
Date of death:	**24 March 2017**
Cause of death:	**INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (DRIVER)**
Place of death:	**Skipton Road & Lake Road, Beaufort, Victoria 3373**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Vladimir Mark Makovnik was 27 years of age at the time of his death. He resided in Beaufort with his parents Jennifer and Vladimir 'Philip' Makovnik. Mr Makovnik worked for Chipaway Trees, a company operated by William Ross and Leanne Day. He was employed as a labourer and his duties included cleaning up roadsides by placing green matter and logs into a 'chipper' machine.

2. At approximately 8.30am on 24 March 2017, Mr Makovnik attempted to perform a 'U-turn' in a work vehicle, a 1996 Mazda utility, at the intersection of Lake Road and Skipton Road. During the course of conducting the 'U-turn', Mr Makovnik stopped to give way to a southbound vehicle which had indicated the intention to turn left into Lake Road; the front quarter panel of the utility was blocking the northbound lane of Skipton Road.

3. At this time, a blue and white prime mover travelling northbound drove around the blind leftward bend in Skipton Road, approximately 80 metres south of Mr Makovnik's stationary vehicle. The driver of the truck, Mr Remfry, applied the brakes and sounded his horn. He attempted to drive around the utility, but Mr Makovnik quickly drove forward toward Lake Road and directly into the path of the oncoming truck. The vehicles collided and, despite the resuscitative efforts of paramedics, Mr Makovnik died at the scene.

INVESTIGATIONS

Forensic pathology investigation

4. On 27 March 2017, Senior Forensic Pathologist Dr Matthew Lynch practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Vladimir Mark Makovnik's body which included a post mortem computed tomography (CT) scan. The CT scanning revealed bilateral rib fractures, a right pneumothorax and bilateral haemothoraces.

5. Dr Lynch commented on the absence of a transversely oriented bruise or abrasion on the abdomen of Mr Makovnik's body. When these types of injuries are present, they may be indicative of a seatbelt worn during a collision.

6. Toxicological analysis of Mr Makovnik's post mortem blood did not identify the presence of ethanol, common drugs, nor poisons.

7. Dr Lynch formulated the medical cause of Mr Makovnik's death as injuries sustained in a motor vehicle collision as a driver.

Police investigation

8. Victoria Police attended the intersection of Lake Road and Skipton Road subsequent to the collision in which Mr Makovnik sustained fatal injuries. Police officers observed that Skipton Road was a two-way, two lane road running in a predominantly north – south direction. The bitumen lanes were 3.1 metres wide, in good repair and divided by broken white lines. There were gravel verges beyond the bitumen and the nature strip was covered in vegetation and large trees. Approximately 50 metres north of the Skipton Road and Lake Road juncture, there were Armco barriers erected on either side of the road before a steep embankment. The relevant speed limit was 100 kilometres per hour.

9. Leading Senior Constable (LSC) Jaclyn Loveday was the nominated coroner's investigator.[1] At my direction, LSC Loveday investigated the circumstances surrounding Mr Makovnik's death, including the preparation of the coronial brief. The coronial brief contained, inter alia, statements made by Philip Makovnik, Mr Makovnik's co-worker Tom McWilliam, and witness Garry Haslem.

10. At approximately 7.15am on 24 March 2017, Mr Darryl Remfry commenced work for Montgomery Construction and Rail in Bennett Lane, Beaufort. Mr Remfry had held a Heavy Combination licence for the past three years and had worked for Montgomery Construction for the previous six months. Mr Remfry drove a white and blue 2007 Mack Trident Prime Mover (UYM-229) towing a trailer (V28-840) and a white 2013 tipper. Upon completing a check of the truck, he ascertained that there were no apparent issues with the operation of the vehicle and commenced his work. Mr Remfry had never had a collision when driving a Heavy Vehicle.

[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

11. At approximately 7.20am, Mr Remfry drove the truck toward the DE Quarry situated on Geelong Road. At approximately 7.50am, he arrived and quarry employees loaded the trailer. The scales indicated that the weight of the load, including the truck, was 45 tonne. The loading process spanned approximately 20 minutes. Subsequently, Mr Remfry commenced the return trip to Beafort via Skipton Road.

12. At approximately 7.55am, Mr Makovnik and his colleague Mr McWilliam arrived at the Chipaway Trees company yard, located at 125 Lexton Road in Beaufort. In his statement to police, Foreman Mr Wayne Pett said that he directed the labourers to erect signage on Lake Road. Mr Pett stated that he directed Mr Makovnik and Mr McWilliam to:

    'turn left into Lake Road (from Skipton Road) and put two 40 km/h signs up and then travel right down Lake Road until you reach Cemetery Road and put two 40 km/h signs up there, as that was the end we were working on.'

13. At approximately 8.15am, Mr Makovnik left the company yard driving a white 1996 Mazda utility (ZAR-625) with Mr McWilliam in the front passenger seat. They stopped at the local milkbar on Lawrence Street and purchased items before continuing south. Mr Makovnik drove the vehicle left onto Havelock Street and then right onto Lake Road. At this time, Mr McWilliams exited the vehicle and erected signs that indicated that work was being done in the area. They continued to the juncture of Lake Road and Skipton Road where they erected more signage.

14. At approximately 8.30am, Mr Makovnik attempted to perform a 'U-turn' in the intersection of Lake Road and Skipton Road. Mr McWilliam stated that, during the course of the 'U-turn', Mr Makovnik stopped to give-way to a vehicle towing a trailer, which was travelling southward on Skipton Road. Mr Garry Haslem was driving that vehicle.

15. In his statement to police, Mr Haslem said that he was approximately 150 metres from the intersection when he indicated his intention to turn left into Lake Road. At approximately the same time, Mr Makovnik drove the utility into the intersection to commence the 'U-turn'. Mr Haslem stated that the utility stopped to give way to him with the front quarter panel blocking the northbound lane of Skipton Road. He said that he saw a truck, which was driven by Mr Remfry, appear at the bend in the road

approximately 80 metres south of the intersection and that he was immediately concerned about the potential of an accident.

16. Mr Remfry drove his truck around the blind leftward bend in Skipton Road. He was slowing the truck and travelling between 80 and 90 kilometres per hour; he was aware of the speed limit decreasing from 100 to 80 kilometres per hour upon entering the Beaufort area. Mr Remfry observed the utility driven by Mr Makovnik blocking the northbound lane and the vehicle driven by Mr Haslem in the southbound lane that was indicating the intention to turn left onto Lake Road.

17. Mr Remfry applied the airbrakes, slowed the truck and moved to drive behind the utility as it turned into Lake Road. However, he saw the utility begin to slowly reverse back into the northbound lane, consequently he sounded his horn when the vehicles were approximately 25 metres apart. Mr Remfry crossed into the southbound lane to avoid impact as the northbound lane was entirely blocked. He stated that the utility then quickly drove forward, toward Lake Road and into the path of his truck, affording him no opportunity to avoid a collision.

18. Mr Remfry applied his brakes fully and the truck impacted the utility. The utility came to rest approximately 26 metres from the point of impact and the truck travelled a further 18 metres north after colliding with the Armco barrier and subsequently into a large tree located on the western side of Skipton Road.

19. Subsequent to the collision, Mr Haslem returned to the intersection and directed Mr Remfry, who was very distressed, to contact emergency services. Mr Haslem attempted to ascertain whether Mr Makovnik had a pulse. Another person, a nurse, arrived at the scene and provided first aid to Mr Makovnik. She commenced resuscitative breaths in situ when his pallor became bluish. Paramedics arrived and removed Mr Makovnik from the vehicle to commence Cardio Pulmonary Resuscitation (CPR). Despite their efforts, Mr Makovnik was declared deceased at the scene.

20. In his statement to police, Mr McWilliam said that he did not observe the truck in the northbound lane until the horn was sounded. He did not indicate whether Mr Makovnik had checked the northbound lane before commending the ‘U-turn’ nor if he had seen the truck.

21. LSC Silas Stephens spoke to Mr Haslem immediately after the incident. Mr Haslem expressed to the police officer that the utility *'had its nose out on the roadway'* as Mr Makovnik waited for Mr Haslem to turn left onto Lake Road. He told LSC Stephens that, after he had turned left, he observed *'that the utility pulled out in front of the truck as though the driver had not seen the Mack truck travelling north.'*

22. Mr Remfry underwent a police operated breath test at the scene and the results were negative for the presence of alcohol.

APPLICATION FOR AN INQUEST

23. By Form 26 application dated 16 February 2018, Mr Makovnik's father, Philip Makovnik, made an application pursuant to section 52(5) of the **Coroners Act 2008** (the Act) that an inquest be held as part of my investigation into Mr Makovnik's death. The Form 26 was received by the Court on 19 February 2018.

24. The Form 26 received from Vladimir 'Philip' Makovnik identified concerns related to the death of his son. The following reasons are contained in the application:

> *'I am dissatisfied with the level of investigation into the circumstances surrounding Mark's death. I believe that there are factors regarding the manner in which the events leading up to the death were assessed or taken into account in the coronial enquiry.'*

FAMILY CONCERNS

25. The Applicant expressed concerns in his statement[2] that give context to those reasons contained in the application:

    a. Mr Makovnik was not trained in erecting signage;

    b. Mr Makovnik's work vehicle was unsafe and not in roadworthy condition.

26. In his statement, Philip Makovnik said that the 1996 Mazda utility (ZAR-625) was unsafe and that seatbelts could not be worn comfortably as they continuously retracted and locked. He said that the left door mirror permanently pointed down to the ground.

[2] Statement of Vladimir Philip Makovnik 27 April 2017, *Coronial Brief of Evidence* COR 2017 1356, [20].

Mr Makovnik's father also highlighted his concern that the signage cage probably blocked his son's view of the northbound lane and the oncoming truck. He indicated that the LPG gas system was fitted by the employer did not comply with safety standards. Philip Makovnik stated that the front tyres on the vehicle were new but the rear tyres were bald. He was concerned the equipment, signs and occupants meant that the vehicle's weight capacity was exceeded.

27. Additionally, in his statement to police, Mr McWilliam indicated that the Mazda utility was *'past its time'*. He said that the gas system did not work and had to be checked every day. Additionally, he stated that the fuel gauge did not work so it was not clear whether there was petrol in the vehicle.

FURTHER INVESTIGATION

Condition of the Mazda Utility ZAR-625

28. On 24 March 2017, Mr Dempsey Davis of Harris Accident Repair Centre towed the white Mazda utility to the Ararat depot for inspection by Victoria Police. On 5 June 2017, Senior Constable (SC) and Senior Motor Mechanic Brett Gardner of the Mechanical Investigation Unit conducted a thorough review of the state of the 1996 Mazda B2600 Utility (ZAR-625).

29. On 19 July 2017, SC Gardner provided a report to my investigator. The report summary stated that, prior to the collision, the overall condition of the vehicle would have been good. The rear tyres had very low tread and were unroadworthy, however, their condition would not have contributed to the collision. The brake system and hydraulic system for the clutch would have been operating as intended prior to the collision. The inspection did not reveal any mechanical fault with this vehicle which would have caused or contributed to the collision.

WorkSafe Investigation

30. Mr Makovnik's father raised concerns about appropriate workplace safety and training in his statement contained in the coronial brief. In light of these concerns, I directed my court registrar to contact WorkSafe to determine whether there was an investigation underway. On 6 March 2018, WorkSafe responded and indicated that they were aware

of the death of Mr Makovnik. WorkSafe Inspectors attended the Chipaway Trees company site and made enquiries with Mr Makovnik's employer and supervisor. On the basis of the information obtained in response to those enquiries, a decision was made not to undertake a comprehensive investigation.

Determination whether to hold an Inquest

31. Philip Makovnik's Form 26 application raised concerns related to the safety of Mr Makovnik's work vehicle and the workplace training he had received in relation to erecting signage. Pursuant to section 67(1) of the Act, as Coroner I must, if possible, find the circumstances in which Mr Makovnik's death occurred.[3] The purpose of any Inquest would then be *inter alia* to establish the circumstances surrounding Mr Makovnik's death.

32. I acknowledged the concerns expressed by Philip Makovnik in the Form 26 application, as well as those concerns in his statement that is contained in the coronial brief. However, I noted that some of those concerns extended beyond the coronial jurisdiction. In particular, the training Mr Makovnik received in respect of erecting signs was appropriately investigated by WorkSafe, as the regulator. I identified that WorkSafe elected not to pursue further investigation.

33. In view of Philip Makovnik's concerns regarding the reliability and roadworthiness of the work vehicle driven by his son at the time of his death, I sought a copy of the Mechanical Investigation Unit report on the condition of the 1996 Mazda B2600 Utility (ZAR-625). The report identified that, despite some defects in its condition, the overall condition of the car was good. The inspection did not detect a mechanical fault that would have caused or contributed to the collision.

34. In these circumstances, I concluded that it was unlikely that the holding of an Inquest would advance my investigation, enhance the available evidence or uncover important systemic defects. I acknowledged the distress caused to Philip Makovnik and his family in the wake of his son's death. However, it is not the role of the Coroner to conduct a free-ranging investigation; in my jurisdiction I am obliged to look at the circumstances

[3] I note that this is subject to section 67(2) of the Act.

connected with Mr Makovnik's death.[4] Having reviewed and considered all of the available material, I did not identify definitive issues which would be greatly elucidated by way of a public hearing.

35. I accordingly did not identify a legitimate coronial purpose that was likely to be served by holding an Inquest into Mr Makovnik's death. In the circumstances, pursuant to section 52(6)(b) of the Act, I determined that an Inquest would not be held.

36. On 18 May 2018, I completed a Form 28 *Decision by Coroner whether or not to hold an Inquest into Death* which informed the applicant Philip Makovnik of my decision. Pursuant to section 82 of the Act, Philip Makovnik was afforded three months to lodge an appeal of my decision to the Supreme Court of Victoria (Supreme Court). After which time, I would proceed to finalise this matter by way of a Form 38 *Finding without Inquest*.

Appeal to the Supreme Court

37. On 9 August 2018, the Coroners Court of Victoria (the Coroners Court) received notification from Philip Makovnik's legal representation, Jon Irwin of Irwin & Irwin Law, that he intended to appeal my decision. On 5 September 2018, I received notification of an appeal lodged against my decision not to hold an inquest in this investigation. At that time, there were no dates listed for direction as the Appellant, Philip Makovnik, was yet to file a summons.

38. On 6 December 2018, the Mr Irwin wrote to the Coroners Court in relation to further instructions from his client to propose consent orders that I would, *inter alia*, undertake further investigations.

39. On 12 December 2018, then In-House Legal Counsel for the Coroners Court of Victoria Sarah Gebert[5] responded to Mr Irwin's correspondence on my behalf. Ms Gebert advised that the Coroners Court was unable to enter into the proposed consent arrangement for a number of reasons, including that the Coroners Court had yet to be made a party to the Supreme Court appeal and that there were preliminary

[4] *Harmsworth v The State Coroner* [1989] VR 989 at 996, per Nathan J.

[5] Sarah Gebert has been appointed a Victorian Coroner.

jurisdictional issues to consider prior to any further proceedings. In relation to proposed further investigation, Ms Gebert advised that the Coroners investigation remained open and, in those circumstances, it was open to Mr Makovnik to provide any further material relevant to my investigation.

Cessation of Appeal to the Supreme Court

40. In the fullness of time, it became apparent that Mr Irwin was having some difficulty obtaining instructions from his client in order to progress their appeal.

41. On 15 July 2019, Mr Irwin informed delegates of the Coroners Court and Supreme Court that he had been instructed to discontinue Mr Makovnik's appeal.

42. On 16 July 2019, Supreme Court Senior Registry Lawyer Jennifer Sheehan emailed Mr Irwin and Solicitor Kate Hughes of Victorian Coronial In-House Legal Services (IHLS), indicating that if the proceeding was to be discontinued, it must be by consent or with the leave of the Supreme Court. If the latter, Mr Irwin was to file a summons and supporting affidavit pursuant to rule 20.03(3) of the Supreme Court (General Civil Procedure) Rules 2015).

43. On 18 July 2019, Ms Hughes wrote to Ms Sheehan to state that the Coroners Court would consent to the proceeding being discontinued but noted that it was not yet a party to the proceedings. Ms Hughes asked Ms Sheehan if the Supreme Court would accept signed consent orders from the Coroners Court in that capacity. Ms Sheehan referred the matter to Judicial Registrar Clayton and then informed Ms Hughes that the matter may be finalised in the form she had suggested, as the Coroners Court would be substituted as the respondent despite the fact that no amended notice of appeal has been filed since the order was made.

44. After some delay, Mr Irwin filed the signed consent orders for discontinuing the appeal on 2 September 2019. The consent orders stated that:

    a. The Application dated 16 July 2018 made by the Applicant (Philip Makovnik) be discontinued.

    b. That there be no order as to costs.

Notification of Intention to Finalise

45. Prior to finalising this matter, Court staff wrote a letter to Mr Irwin to inform his client that I intended to complete my Finding into the death of Vladimir Makovnik. In the letter dated 3 June 2020, Mr Irwin was referred to previous correspondence indicating that it was open to him to provide information on behalf of Philip Makovnik for possible further investigation. The correspondence noted that, in the period since the discontinued Supreme Court appeal, I had not received any information requesting further investigation in this matter. Mr Irwin was informed that if the Court did not receive any further communication within fourteen days, I would proceed to finalise my investigation. No further information was provided.

FINDINGS

1. I find that Vladimir Mark Makovnik, born 20 January 1990, died on 24 March 2017 at Skipton Road and Lake Road, Beaufort, Victoria 3373.

2. I find that Vladimir Mark Makovnik tragically died during the course of his employment as a labourer for Chipaway Trees.

3. I find that Vladimir Mark Makovnik drove a 1996 Mazda utility work vehicle (ZAR-625) at the time of his death. I further find that his co-worker Tom McWilliam was in the front passenger seat of the vehicle.

4. I find that Vladimir Mark Makovnik performed a 'U-turn' on Skipton Road, directly in front of the intersection of Lake Road in Beaufort.

5. AND I find that Vladimir Mark Makovnik stopped his vehicle part of the way through the 'U-turn' manoeuvre, blocking the northbound lane of Skipton Road.

6. AND I find that Vladimir Mark Makovnik had stopped his vehicle to give way to southbound traffic; a car driven by witness Garry Haslem.

7. AND I find that Darryl Remfry drove northbound on Skipton Road in a 2007 Mack Trident Prime Mover (UYM-229) towing a trailer (V28-840) and a white 2013 tipper at the time of Vladimir Mark Makovnik's death.

8. AND I find that Darryl Remfry applied the airbrakes, sounded the horn and moved the Prime Mover into the southbound lane in an attempt to avoid a collision with the utility driven by Vladimir Mark Makovnik.

9. AND I find that Vladimir Mark Makovnik moved his vehicle into the southbound lane into the path of the oncoming prime mover, rendering the collision unavoidable.

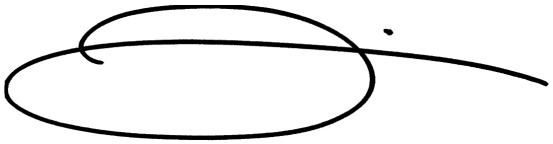
10. I am unable to find whether Vladimir Mark Makovnik had perceived the presence of oncoming, northbound traffic at the time of the collision.

11. I accept and adopt the cause of death formulated by Dr Mathew Lynch and I find that Vladimir Mark Makovnik died from injuries sustained in a motor vehicle collision as a driver.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:
Vladimir Philip Makovnik & Jennifer Makovnik
Transport Accident Commission
Leading Senior Constable Jaclyn Loveday

Signature:



AUDREY JAMIESON
CORONER
Date**: 30 June 2020**