IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2531

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	AC*
Date of birth:	9 April 2000
Date of death:	19 May 2019
Cause of death:	1(a) Injuries sustained in a motor vehicle collision (driver)
Place of death:	Kulkyne Way, Colignan, Victoria

* This is a redacted version of the original signed finding. Names have been replaced with pseudonyms to preserve the privacy of AC's family

INTRODUCTION

1. AC was a 19-year-old man who lived in Colignan with his parents at the time of his death.

2. On 19 May 2019, AC died on the scene of a motor vehicle collision.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. AC's death was reported to the Coroner as it appears to have resulted, directly or indirectly, from an accident or injury, and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

6. 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.

7. 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.

8. 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. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is 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.

IDENTITY

9. On 19 May 2019, AC, born 9 April 2000, was visually identified his friend.

10. Identity is not in dispute and requires no further investigation.

BACKGROUND

11. AC was described as "*an honest, hardworking young man with an amazing work ethic*". At the time of his death, he was undertaking an engineering apprenticeship.

12. On 10 April 2018, AC obtained his driver's licence. His primary mode of transport was his father's Toyota Hilux. According to his mother, the Toyota Hilux "*was serviced regularly as per manufacturer's guidelines and there were no known faults.*" The probationary period on AC's licence was due to expire on 10 April 2022. Since obtaining his driver's licence, he had not committed any traffic offences.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

13. On 17 May 2019, AC was visited at his home by his friend TB and they drank several beers. They remained at AC's home overnight and the following day, they left at approximately 6.00pm to collect their other friend, MA. AC drove his father's Toyota Hilux to MA's home in Colignan, and the three of them then travelled to TB's home in Mildura.

14. After TB showered and dressed, AC drove them to a friend's private party in Mildura. While at the party, AC drank approximately three 375mL cans of beer.

15. At approximately 9.30pm, AC, TB, and four other friends left the party in a taxi and travelled to a local venue, Sand Bar. On arrival at the venue at approximately 10.30pm, AC scanned his driver's licence to gain entry. While at the venue, AC consumed approximately four drinks.

16. At approximately 1.00am, AC left the venue with MA and TB to get food. They then returned by taxi to where AC's car was parked in Mildura for the party. When they arrived at his car, AC suggested to TB that they visit friends who were camping near his home address. MA warned AC against driving, in light of his recent drinking, and that he risked losing his licence. AC ignored his friend's warning and at approximately 1.30am, left in the

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[2] Coronial brief, VicRoads Licence Extract.

Toyota Hilux with TB and travelled along the Calder Highway through Red Cliffs, and then onto Kulkyne Way.

17. At approximately 1.45am, AC and TB arrived at their friends' campsite at the Graces Bend sand bar on the Murray River in Colignan. They spoke with a friend; several other friends were already asleep. AC drank one full strength beer before leaving with TB at approximately 2.00am.

18. They decided they would go for a drive rather than returning home. AC drove past his house on Kulkyne Way and continued in southerly direction along that stretch of road and along the unsealed section of the road.

19. The relevant section of road commences at the Calder Highway and links Red Cliffs with Nangiloc and Colignan. Kulkyne Way begins as a sealed road but transitions to an unsealed road on approach to the Hattah National Park. There is no marked dividing strip on the two-way north-south carriageway.

20. After driving along the unsealed section of road for approximately one kilometre, TB was looking down at his phone when the vehicle suddenly veered to the right. As he looked up, the vehicle struck a tree on the right-hand side of the road. TB estimated that the vehicle was travelling at 100 kilometres per hour or greater at the time of the collision. The vehicle came to a rest in the middle of the roadway facing in a westerly direction.

21. The force of the collision ejected TB from the vehicle and he momentarily lost consciousness. AC remained in the driver's seat as the extensive crush damage to the right-hand side of the vehicle caused the dash, steering wheel and driver's side door to push inwards and pin AC in the seat. Both men were wearing seatbelts immediately prior to the collision.

22. When TB regained consciousness, he immediately rushed to AC, who had sustained visible injuries and was unresponsive. TB entered the vehicle via the passenger side door and commenced cardiopulmonary resuscitation (CPR). He was unable to find his phone to contact emergency services, so he ran along Kulkyne Way in a northernly direction for approximately 1 to 2 kilometres to get help.

23. TB waved down a passing vehicle, which contained MA and AC's brother. TB apprised them of the situation and MA drove to the scene of the collision while TB contacted emergency services.

24. When they arrived at the scene, MA also contacted emergency services. At approximately 3.41am, Ambulance Victoria paramedics and Victoria Police members arrived at the scene. Responding paramedics were unable to find signs of life and pronounced AC deceased at the scene.[3]

Victoria Police Investigation

25. Dr Jenelle Hardiman of the Collision Reconstruction and Mechanical Investigation Unit of Victoria Police conducted an examination of the collision, using a Traffic Incident System report, scene measurements and photographs, to determine the speed of the Toyota Hilux at the time AC lost control of the vehicle. After examining photographs the tyre marks upon the roadway, Dr Hardiman concluded that the Toyota Hilux rotated clockwise before transitioning counter clockwise when AC has steered to the left. This caused the Toyota Hilux to "*rotate sufficiently counter clockwise*" to cause the driver's side of the vehicle to impact the tree.[4]

26. Based on a crash data retrieval report obtained from the Toyota Hilux, Dr Hardiman determined that the vehicle struck the tree at approximately 43.6 kilometres per hour. Taking into account the distance and rate of deceleration, Dr Hardiman concluded that at the time the vehicle began to yaw and rotate, it was travelling at approximately 96 kilometres per hour.[5]

27. According to the summary of evidence prepared by the Coroner's Investigator, an inspection of the Toyota Hilux did not reveal any mechanical fault or malfunction which would have caused or contributed to the collision. The vehicle's airbags were deployed when police members arrived at the scene, which indicated no faults existed with the deployment mechanism.[6]

28. The Coroner's Investigator obtained data in relation to collisions that have occurred in the previous five years to 4 June 2019 in the vicinity of Kulkyne Way, Colignan. A total of 82 collisions were identified to have occurred in the Red Cliffs response zone, 8 of which were fatal, 25 with serious injuries and 49 with other injury collisions. The Coroner's Investigator noted that three fatal collisions occurred within an 8-day period between 19 May and 27 May 2019 in the Red Cliffs response zone.

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[3] Coronial brief, Statement of Senior Constable Daniel Field dated 3 June 2019, 3.
[4] Coronial brief, Statement of Dr Jenelle Hardiman dated 9 August 2019, 2.
[5] Coronial brief, Statement of Dr Jenelle Hardiman dated 9 August 2019, 9.
[6] Coronial brief, Summary of evidence, 8.

29. Of the 82 collisions identified by the Coroner's Investigator, 13 were identified as being on or in the vicinity of Kulkyne Way, three of which were fatal and two involving serious injuries. The two fatal collisions occurred on Kulkyne Way and both involved the driver failing to negotiate a bend on the roadway and both having consumed alcohol.[7]

30. Police members noted that the roadway itself was in a reasonable condition; however, the relevant section of road does not have overhead lighting. Visibility at the time of the collision would have been limited due to limited lighting and the use of headlights only. The trees and vegetation in the area of the collision site did not affect driver visibility. Weather data from the Bureau of Meteorology revealed that there were no hazardous environmental conditions at the time of the collision.[8]

31. The default speed limit at this section of road is 100 kilometres per hour, as there are no signposted speeds and it is considered a rural road. The deviation in the roadway is highlighted by chevron hazard marker signs.

32. The Coroner's Investigator considered the default speed limit of 100 kilometres per hour at this section of road to be unsafe, particularly as it is an unsealed road, and suggested a lowered signposted speed limit of 80 kilometres per hour would reduce the likelihood of further incidents.

CAUSE OF DEATH

33. On 21 May 2019, Dr Victoria Francis, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 24 May 2019. In that report, Dr Francis concluded that a reasonable cause of death was '*Injuries sustained in a motor vehicle collision (driver)*'.

34. Dr Francis consulted a post-mortem computed tomography (CT) scan, which revealed multiple traumatic injuries.

35. Toxicological analysis identified the presence of ethanol at a blood alcohol concentration of 0.10g/100mL and 0.11g/100mL in blood and vitreous humour, respectively. No other common drugs or poisons were detected.

36. The legal limit for blood alcohol concentration for fully licensed car drivers is 0.05g/100mL. The legal limit for probationary drivers is 00.00g/mL.

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[7] Coronial brief, Summary prepared by Coroner's Investigator, 6.
[8] Coronial brief, Summary prepared by Coroner's Investigator, 6.

37. I accept Dr Francis' opinion as to cause of death.

38. It appears alcohol, speed and inexperience when driving were factors in AC's death.

FINDINGS AND CONCLUSION

39. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that AC, born 9 April 2000, died on 19 May 2019 at Kulkyne Way, Colignan, Victoria, from injuries sustained in a motor vehicle collision (driver) in the circumstances described above.

RECOMMENDATIONS

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

1. That VicRoads consider reducing the speed limit on the unsealed section of Kulkyne Way, Colignan, approaching Hattah National Park, to 80 kilometres per hour.

I convey my sincere condolences to AC's family for their loss.

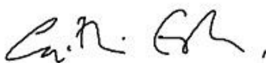
Given that I have made a recommendation, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

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

Senior next of kin.

Senior Constable Daniel Field, Victoria Police, Coroner's Investigator.

Signature:



CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 27 November 2020