IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003668

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Kate Despot
Deceased:	Bikram Dangol
Date of birth:	13 January 1988
Date of death:	26 July 2018
Cause of death:	1(a) Head and neck injury in a motorcycle incident
Place of death:	Western Ring Road & M80 & M1 on ramp, Laverton North, Victoria, 3026

INTRODUCTION

1. On 26 July 2018, Bikram Dangol (**Mr Dangol**) was 30 years old when he died as a result of injuries sustained in a motorcycle incident.

2. Prior to his death, Mr Dangol worked as a production welder. He resided with his wife and family in Williams Landing.

THE CORONIAL INVESTIGATION

3. Mr Dangol's death was 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.

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Dangol's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Bikram Dangol, including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

7. On 25 July 2018, Mr Dangol worked an afternoon shift at his workplace in Campbellfield, commencing at 2.25pm. He finished work at 11.55pm and left his workplace on his black

[1] 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.

2016 Yamaha MT07 motorcycle (**'the motorcycle'**). He regularly rode his motorcycle to and from his workplace.

8. Mr Dangol took his usual route home and rode on the Western Ring Road. He exited the Western Ring Road onto the Princes Freeway via the Geelong-bound on-ramp (**'the on-ramp'**) at about 12.29am on 26 July 2018. He overtook another vehicle to take the Geelong-bound exit.

9. Fellow motorist, Atem Ring (**Mr Ring**), was driving his black 2003 Honda CRV SUV (**'the Honda'**) and was overtaken by Mr Dangol. Mr Ring exited the Western Ring Road via the same exit ramp as Mr Dangol. As he approached the bend, he observed Mr Dangol's motorcycle lying on the ground ahead of him, with Mr Dangol also lying on the road. He immediately pulled his car over and stopped to see if he could assist.

10. Behind Mr Ring was Ramon Brown (**Mr Brown**), driving a white and blue 2010 Freightliner Argosy 'cabover' prime mover (**'the truck'**), towing two trailers. Mr Brown observed the Honda ahead of him slowing down and initially thought that it was slowing due to the road works in the area. Mr Brown had already slowed his truck down as he was familiar with the area and knew there were ongoing road works. Mr Brown was unsure what the Honda was doing, as it appeared to be slowing down more than expected.

11. Mr Brown moved into the left-hand lane to avoid hitting the Honda. As he passed the Honda, he observed what appeared to be a motorcycle taillight on the ground. He initially thought that the Honda collided with the motorcycle, however he then heard a noise under his truck. He was unsure whether he had collided with the motorcycle or Mr Dangol. As he brought his truck to a stop, the rear trailer "*jack-knifed*" and collided with the rear of the Honda, causing extensive damage.

12. Mr Ring was able to climb out of the Honda, however his friend in the passenger seat was trapped. Mr Ring called Triple Zero and requested an ambulance, whilst passing motorists stopped to provide assistance.

13. Ambulance Victoria arrived on scene at 12.34am and immediately attended to Mr Dangol, who was trapped under the truck. Paramedics noted that Mr Dangol had sustained significant injuries and was bleeding heavily. They determined that Mr Dangol's injuries were incompatible with life and did not attempt to extricate or resuscitate him. He was sadly declared deceased at the scene.

14. Victoria Police attended the scene following the collision and investigated the cause and circumstances of the incident. Mr Ring and Mr Brown provided statements to police and were required to undergo mandatory alcohol and drug testing. Both drivers returned negative results for alcohol and illicit substances and were both cleared of any wrongdoing in connection with the incident.

Identity of the deceased

15. On 27 July 2018, Bikram Dangol, born 13 January 1988, was visually identified by his wife, Bina Rajthala.

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

Medical cause of death

17. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine, conducted an autopsy on 31 July 2018 and provided a written report of his findings dated 23 August 2018.

18. The post-mortem examination revealed a fracture to the upper cervical spine with associated subdural haemorrhage and subarachnoid haemorrhage around the brain on microscopic examination. Dr Burke opined that the absence of blood in the peritoneal cavity (abdomen) in the setting of liver and mesenteric rupture would indicate that Mr Dangol died rapidly in the incident.

19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commonly encountered drugs or poisons.

20. Dr Burke provided an opinion that the medical cause of death was 1 (a) Head and neck injury in a motorcycle incident.

21. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS

Police investigation at the scene

<u>Collision location</u>

22. Victoria Police attended the scene of the collision and investigated the cause and circumstances of the collision. At the location of the collision, road works were being undertaken. The Western Ring Road is a 100 km/h zone, however on this occasion, the applicable speed limit was 80 km/h on the approach to the ramp, which changed to 60 km/h, just prior to the collision location.

23. At the location of the collision, the on-ramp was a two-lane, one-way road in good condition. The lanes were separated by broken white lines, with solid white lines marking the outer edges of the lanes, also known as fog lines.

24. At the time of the collision, the road surface was dry. However, within the collision scene, there was a large wet patch over the road surface due to a leaking water main. The original fog line at this location had been painted over in black paint to blend in with the road surface and so as not to confuse drivers. Prior to the 60 km/h sign, there was the section of black painted over line with no abrasive material. This section without abrasive material was about 1.5 metres from the fog line of the right-hand lane.

25. On the eastern fog line of the carriageway was a section of painted over white line that was also water soaked. This section of the fog line was brittle and broke away easily. There was also a section of new white line that was permanently wet.

26. Police noted that the commencement of scraping on the roadway as well as dual tyre skid marks occurred 8.6 metres south of the 60 km/h sign. There were no kinks or sudden changes in the scrape marks to suggest that the motorcycle was struck by any other vehicle or item whilst it was sliding along the ground.

Condition of vehicles involved

27. Mr Dangol's motorcycle was noted to have no visible damage on its rear, front or right-hand side. There was an unknown shiny substance on the outside of the tyres, believed to be a tyre shine or similar product. It was not noted on the running area of the tyre.

28. The Honda sustained an impact to the rear passenger side, the roof was peeled forward, and the rear passenger side door had been forced open. The front passenger door had been removed, and the skin of the rear passenger door and the rear passenger side of the boot were dislodged. There was no contact to the front of the vehicle that could be identified.

29. The truck sustained scratches and scuffing to the driver's side bumper. Mr Dangol's body was trapped between the front axle and the driver's side fuel tank. The two trailers were still connected to the prime mover, with the rear quarter panel of the Honda lodged in front of the toolbox on the second (or 'B trailer'). Investigators opined that the B trailer collided with the rear of the Honda.

Road surface

30. Investigators noted some of the black paint on the road surface contained an abrasive material to improve the frictional resistance of its surface. Painted white lines offer less frictional resistance than a bitumen road surface.

31. Investigators noted that the frictional resistance of the section of the line without abrasive material was considerably more slippery than either the road or the sections with abrasive materials. Considering the black painted over the line in this collision, the paint had filled up the roughness in the aggregates of the road surface and had eliminated almost all the macro texture of the line. The abrasive material on the paint is there to provide micro texture, which was also missing.

32. The investigator concluded that the loss of macro texture, due to the black paint, and micro texture, being the lack of abrasive material on the black paint, would have led to the loss of control by the rider, if the rider crossed over the line. There were no other reasons provided as to why Mr Dangol lost control of his motorcycle. Excessive speed or rider behaviour were also not considered factors in the incident.

History of road works in the area

33. The Western Roads Upgrade Project (**WRU**) consists of eight capital upgrade projects as well as a package of works to rehabilitate and maintain Melbourne's western suburban arterial roads. Package 5 includes the duplication of Doherty's Road from Fitzgerald Road to Grieve Parade in Laverton North and Altona North. This includes duplication of the bridge above the Princes Freeway. This particular package of works was subcontracted to Winslow Construction Pty Ltd ('**Winslow'**).

34. In order to carry out the required works to Doherty's Road, long-term traffic management measures were implemented in July 2018. This involved, amongst other measures, a change in the speed limit to 60 km/h at the location of the collision, on or about 3 July 2018.

35. The area was audited during the day and the night of 7 July 2018. Amongst the audit findings was an isolated solid white line that was considered redundant and required blacking out. According to the audit findings report, this line was blacked out on the night of 23 July 2018.

36. There was no mention in the audit findings report of the water leak which was present at the time of the collision.

History of water leak

37. On or about 10 May 2018, Winslow's Safety Coordinator, Mark Kelly, attended the area near the collision location in preparation for the on-site work. Mr Kelly noticed *"large water soaked areas to the south western end of Altona Memorial Park, including the location of a proposed future roundabout on Doherty's Road*". As he continued his inspection, Mr Kelly observed the south-western end of the Altona Memorial Park was "*heavily waterlogged and flooded in areas*". He assumed it was a leaking water main and called City West Water[2] (, the relevant water provider for that area. He noted the area of the leak and the significant volume of water that was present.[3] Mr Kelly stated that he did not receive any response from GWW to his call and believed that he made "*three or four further attempts*" to contact GWW about this issue in the weeks that followed.[4]

38. On that same day, Senior Project Engineer from the Westgate Tunnel Project (**WGTP**), Arthur Bletsios, emailed GWW and reported the leak. This email was received by Andrew Edwards, of GWW. Mr Edwards then sent an email to the "City West Water Report a Fault" email address, requesting Programmed Facility Management Pty Ltd ('**Programmed'**) attend the site and investigate the cause of the leak. In his statement, GWW Water Operations Co-ordinator Dylan Thomas, stated that he attended the site, although did not stipulate when he attended the site. Mr Thomas stated:

> *As per normal protocol, upon receiving the case, I went out to site to inspect the water leak in the south west area adjacent to the M80 Ring Road. Upon inspection, it appeared that the water leak was coming from any City West Water asset*.[5]

[2] Superseded by Greater Western Water following the dissolution of City West Water on 30 June 2021. I note for consistency, I will refer to this entity as GWW, unless directly quoting a witness or statement.
[3] Coronial Brief **(CB)**, Statement of Mark Kelly, page 159.
[4] CB, Statement of Mark Kelly, page 159.
[5] CB, Statement of Dylan Thomas, page 228.

39. The error in this statement makes it difficult to interpret his intention. I presume he intended to say, "*it appeared that the water leak was **not** coming from any City West Water asset*".

40. Mr Thomas explained that between 10 May and 7 June 2018, he worked with the Programmed team to identify the location and source of the leak. During this investigation, they concluded that the source of the leak was originating "*from an area away from the City West Water asset*". On or about 7 June 2018, Mr Thomas notified GWW that the leak did not appear to be a GWW asset. Mr Thomas contacted the VicRoads Account Manager at GWW, Des Horton, and asked for the appropriate contact at VicRoads to discuss the issue with.[6]

41. In mid to late-May 2018, Sergeant Timothy Noisette (**Sgt Noisette**) of Victoria Police, drove through the collision site on his motorcycle. He reported that he encountered an unexpected patch of water on the road which caused his motorcycle to lose traction. He was able to avoid losing control of his motorcycle and was fortunately not injured during the incident. Sgt Noisette reported that the water was unusual, as it was not raining at the time and the road was dry everywhere else. He paid attention to that location every time he travelled on the ramp, and noted that it was wet every day, despite no inclement weather. He concluded that it was not weather-related and reported the issue to GWW on 4 July 2018. It does not appear that Sgt Noisette received any response from GWW.

42. On 20 June 2018, Mr Kelly attended the site and observed water running across the Western Ring Road off-ramp (from east to west), at the same location he observed on 10 May 2018. He described the water as "*'sheeting' across the road with the same volume you would expect to see after a light to medium rain shower*". Mr Kelly called GWW and reported the leak again.

43. According to Mr Thomas, Mr Horton then proceeded to identify the correct person at VicRoads between June and July 2018, so that a Red Notice could be issued. A Red Notice was issued to the owner of an asset that requires repairing. During this time, Mr Kelly continued to call GWW to report the issue.

44. On 30 June 2018, Rapid Line Marking (**RLM**) attended the Western Ring Road to commence work, blacking out redundant lines and installing new lines on the off-ramp to the Princes Freeway.[7] RLM was sub-contracted by Winslow to complete the line-marking work. On the first night of their works, RLM supervisor Simon Hill (**Mr Hill**), reported to Winslow that

[6] CB, Statement of Dylan Thomas, page 228.
[7] CB, Statement of Simon Hill, page 248.

they were unable to remove line markings on a section of road, due to water running across the road.[8]

45. On 16 July 2018, Mr Kelly sent GWW five aerial images taken from Nearmaps via a "*report fault*" email address.[9] These images were dated 29 November 2014, 14 December 2015, 28 August 2017, 10 October 2017, and 4 April 2018. Mr Kelly described the vegetation as "*lush*" in the area of the leak, whilst the surrounding area was "*dry and brown*". He opined that the leak may have existed from at least November 2014. That same day, Mr Kelly also called the Energy and Water Ombudsman Victoria (**EWOV**) and made a complaint about GWW's lack of response to the water leak.

46. The EWOV escalated the complaint to GWW Complex Case Investigator, Marianne Lourdes (**Ms Lourdes**) on 17 July 2018. The EWOV forwarded Mr Kelly's coplaint to her, which stated that the leak was a "*safety hazard for road users*". The next day, Ms Lourdes called Mr Thomas, and he provided her with a background of the matter and advised her of his belief that the leak was due to a VicRoads fire service line.

47. During that call, Ms Lourdes enquired whether a Red Notice would be issued to VicRoads to repair its asset. Mr Thomas subsequently called Mr Horton to obtain the contact details of the relevant VicRoads staff so that he could provide the Red Notice to VicRoads.

48. On 19 July 2018, Mr Kelly contacted GWW again, explaining that he had contacted the ombudsman and the media about the leak and that GWW sent someone out named David on Monday who inspected the leak, however no repair had occurred.

49. On 20 July 2018, Ms Lourdes called Mr Kelly to discuss the leak. Mr Kelly repeated his concern with the leak in detail, his observations of the water running over the road and the water-logged vegetation in the area. That same day, Mr Thomas corresponded with Ms Lourdes via email and his interactions are as follows:

> *At 11.32am, I emailed Marianne Lourdes and advised her that I was waiting for Des Horton to identify the correct VicRoads contact so that the Red Notice could be provided to VicRoads.*

[8] Ibid, page 249.
[9] CB, Statement of Mark Kelly, page 160 and 164.

At 2.23pm, I emailed Marianne Lourdes to inform her that Des Horton had emailed VicRoads in order to determine the best contact person and that Programmed Facility Management Pty Ltd was waiting for a response.

At 3.00pm, Des Horton emailed me and Marianne Lourdes to advise that Michelle Stewart, Surveillance Manager Roadside Management, VicRoads had called him to advise that she may have located the correct internal VicRoads contact.

50. Ms Stewart recalled that on 20 or 23 July 2018, she met with Bob Sciacchitano (**Mr Sciacchitano**), who was a Surveillance Officer in the Routine Maintenance division of VicRoads. Mr Sciacchitano reported that Road Services (a division of VicRoads, now named Strayline Road Services) had received a report from a plumber about the fire hydrant. It is unknown when the plumber attended the site.

51. RLM's last shift to complete the line markings was on 23 July 2018. Mr Hill reported that during their three-week period of work at the site, they encountered difficulties removing the redundant line and installing new lines due to the water running over the road. Mr Hill reported that this water was present the entire time they were conducting their works. Mr Hill also noted that his team experienced difficulties installing the black plastic over the redundant lines and that the new lines were not successfully installed due to the inability of the new lines to dry and adhere properly to the road surface.

52. In the early hours of 24 July 2018, the Operations Coordinator of Infrastructure, Radomir Divljan, at Trafman Management (**'Trafman'**) emailed two managers at Trafman and copied in two managers at Winslow, advising that the line marking work at the site was completed, however there was a section that could not be blacked out due to the water running onto the road. He noted that "*[n]ot even blow torch could help, fair bit of water running on it"*. He also opined that "*It is not big issue as it sits in the middle of the running lane approximately 2m long*".

53. Later that day, Mr Kelly emailed the Community and Stakeholder Coordinator at Winslow, Shondelle Mathews (**Ms Mathews**), and requested that she speak with VicRoads about the leak. He noted the serious safety concerns for motorists, as well as the ongoing impacts the leak would have to the work they were expected to perform on the site. Ms Mathews forwarded Mr Kelly's email to some contacts at VicRoads, and to Raj Thurman, Project Manager at Major Road Projects Victoria (**MRPV**). Mr Thurman forwarded the email to a contact at MRPV who would be able to assist.

54. Mr Thomas also spoke to Ms Mathews on the phone that day. Ms Matthews reported that a plumber had attended the site, that the leak was a fire service leak on a VicRoads asset and that VicRoads would locate the appropriate people internally to repair the leak.

55. Ms Stewart decided to drive to the location of the collision on the afternoon of 25 July 2018. She attempted to stop her car in the emergency lane and look for the water, however she reported that she was unable to stop safely. She reported that she did not observe any water on the road at the time and that if she had seen water, she would have "*phoned VicRoads' Traffic Management Centre to report the water on the road*".

56. On 10 August 2018, Mr Thurman responded to Ms Mathews' email dated 24 July 2018, with two individuals at VicRoads who previously may have been worked on the leak. It appears that Mr Thurman did not make the connection between the 24 July 2018 email and the leak that was fixed on 26 July 2018, after the incident.

Rectification works post-incident

57. At about 1.00am on 26 July 2018, Acting Supervisor Construction at SprayLine Road Services (**'SprayLine'**), Tom Pywell, was notified by his colleague, Ali Mohammed, of the incident that occurred involving Mr Dangol. Mr Pywell asked Mr Mohammed to organise some earth moving equipment, as he thought it may be required to locate the source of the water leak. Mr Pywell attended the scene at about 4.45am to assist with management of the scene. The earth moving equipment requested by Mr Pywell arrived on scene at about 5.30am.

58. At about 6.00am on 26 July 2018, VicRoads called the GWW Operational Control Centre, and the call was answered by the Programmed dispatch team. VicRoads advised Programmed of a water leak on the Western Ring Road. The unknown Programmed employee who answered the call spoke with Daryl Esdaile for technical advice, and Mr Esdaile responded that GWW did not have assets in that location, other than a 450mm main at the bottom of the embankment.

59. The earth moving equipment located the source of the water leak at about 6.30am. Mr Pywell observed "*water shooting out approximately 3 to 4 feet into the air*". Mr Pywell noted the lugs on the top of the fire hydrant had rusted and two lugs had broken off, with water leaking from a blue coloured shut off valve. Mr Pywell directed the earth moving equipment operator to dig a trench and redirect the flow of water away from the road. Mr Pywell also called for a plumber to attend the scene.

60. At 7.18am, the GWW Operational Control Centre called the Programmed dispatch team to request they attend the collision location to provide assistance in relation to the water leak. This call was answered by Mr Thomas, who advised that the leak was not related to a GWW asset. Mr Thomas immediately contacted Ms Stewart and reminded her that the asset was a VicRoads asset.

61. At about 8.00am, two plumbers from Western Industrial Plumbing (**WIP**) arrived on scene, as requested by Mr Pywell. The plumbers informed Mr Pywell that it was necessary for the water flow to the fire hydrant to be turned off and they called GWW to request assistance with the task. Mr Pywell overheard that GWW "*initially disputed they had infrastructure that high up beside the road but the plumber assured them the fire hydrant was connected to their infrastructure*".

62. GWW arrived on scene at about 9.00am and assisted the WIP plumbers to locate the connection for the fire hydrant. They eventually shut down the water main supply in the area, which prevented water flowing to the fire hydrant.

63. A line marking unit was utilised to remove the road surface and resin, and new lines were installed that afternoon. The team used water-blasting in order to complete the works. The off-ramp was re-opened at about 4.00pm.

Analysis of pre and post-incident responses

64. I note that from June to July 2018, Mr Horton *"continued to seek to identify the correct person at VicRoads so a Red Notice could be issued"*. It is unclear from Mr Thomas' statement what contact Mr Horton made with VicRoads during this time. When he emailed VicRoads on 20 July 2018, he received a response later that day with a possible contact. It is also unclear to me what occurred throughout the preceding weeks in June and early July 2018 that led to the delay in obtaining the contact.

65. In a similar fashion, two and a half weeks were also required for Mr Thurman to identify the appropriate contact person at VicRoads. I am not criticising Mr Thurman and Mr Thomas; I simply note how difficult it was for people working within the relevant government departments to identify the appropriate contact person.

66. I also note the absurdity of the situation in which this issue was 'handballed' between various companies and entities. At the time of the collision, VicRoads, Trafman, Programmed, MRPV, GWW, and Winslow were all aware of the water leak, with the latter two aware of it

for about two months prior to the collision. Whilst various people within these entities were all trying to resolve the issue, it is apparent that nothing constructive occurred until after the fatal collision.

67. I find it unusual that GWW did not have a nominated contact person at VicRoads, or even a shared inbox monitored by VicRoads where it could send an enquiry. Although the frequency of this situation is unknown, it appears to me that GWW does not have records of a VicRoads contact readily available to escalate water leak issues arising out of its water assets in a timely manner.

68. If the fatal incident had not occurred when it did, I query how much longer it would have taken for the leak to be rectified. Even *after* the collision occurred, there were arguments between GWW and other entities about the ownership of the water assets in question. I note that the issue was rectified the same day as the collision, so it is evident that it was not a particular onerous or complex task.

Procedural fairness responses

69. As a matter of procedural fairness, the Court wrote to Winslow and GWW to provide them with an opportunity to respond to proposed adverse comments. Their submissions are summarised below.

Winslow's response

70. Solicitors on behalf of Winslow submitted that my proposed findings did not articulate any steps that Winslow should have taken and that they did not pay sufficient regard to all the relevant evidence (submitted as an annexure to their submissions). Winslow's solicitors submitted that:

> *Winslow had no power to do anything about the situation other than draw it to the attention of those responsible for water assets in the area. GWW and VicRoads were the partiers with the ability to take practical steps to address it. To include Winslow with GWW in the context of Winslow's persistence in pursuing the issue, in contrast with the significant delay by GWW, is unfair. In particular, we note the delay from 7 June 2018, when Mr Thomas became aware that the asset was a VicRoads asset, and 18 July 2018, which is the first date where there is evidence of any specific contact between GWW and VicRoads.*

71. I accept Winslow's submission, namely, that it made repeated requests to GWW in an attempt to have the leak repaired, including by contacting the EVOW.

GWW's response

72. Via their solicitors, GWW explained my proposed adverse comment does not properly reflect the proactive steps taken by GWW in relation to the leak and fails to give adequate weight to VicRoads' conduct, namely:

    a) Failure to maintain a designated and readily identifiable contact person with respect to the asset, as well as its delay in properly identifiable contact person with respect to the asset.

    b) Its delay in properly identifying and confirming ownership of the relevant asset.

73. GWW submitted that it took proactive steps, upon being notified of the leak on 10 May 2018 to inspect the site the same day. At the time, GWW reported that the leak "*did not cause water to run onto the off-ramp and was only impacting the nearby grasslands*". Mr Thomas used a Geographical Information System (**GIS**) to confirm the location and relevant information abot assets owned by GWW. GWW did not have access to information or the location of assets owned by other entities, including VicRoads.

74. GWW further submitted that it took steps to confirm the proper owner of the assets to notify it of the leak. With only the information contained in the GIS, Mr Thomas could not accurately confirm the proper owner and surmised it was VicRoads, given the asset's proximity to the Western Ring Road. GWW stated that once it received Mr Kelly's notification, it attempted to call him several times but were unable to reach him.

75. GWW explained "*[i]n circumstances where GWW did not own the asset and therefore could not undertake any of the required repairs, GWW undertook steps to speak with the appropriate contact at VicRoads to notify them of the leak and offered its assistance in locating the asset*".

76. GWW listed the "*considerable steps*" taken by Mr Horton to identify the correct VicRoads contact, namely:

    a) Speaking to Mark Abrahams of GWW about the appropriate VicRoads contact.

    b) Upon being advised to speak with Michael Kyriannis of VicRoads, attempting to call Mr Kyriannis' phone number and leaving a voice message.

c) Speaking with Shane Lay of GWW about other potential VicRoads contacts.

d) Sending an email to four potential VicRoads contacts seeking assistance, to which no response was received.

e) Making multiple further attempts to contact Mr Kyriannis and leaving voice messages.

f) Calling all VicRoads phone numbers between those ending in 1135 and 1148 to speak with any VicRoads employee.

g) Emailing a Director of VicRoads, their personal assistant, and the four above-mentioned VicRoads' employees seeking assistance (which was eventually successful).

77. GWW noted that it was not the only entity who faced difficulties contacting and reporting the leak to VicRoads. As noted above, Mr Thurman of the MRPV also experienced difficulties finding the correct contact details. GWW submitted that I should also acknowledge that the difficulty was, in part, caused by VicRoads' failure to have in place a designated contact person who was responsible for receiving notification of issues with potential VicRoads assets. It noted that had VicRoads provided an easily accessible contact, there may have been less delay in the matter being reported to VicRoads.

78. GWW submitted that VicRoads' lack of clarity regarding the ownership of the asset:

a) Actively contributed to the delay in repairing the asset; and

b) Evidence of process and communication failures within VicRoads more broadly, that may have (indirectly) contributed to the delay.

79. GWW acknowledged that there was delay and difficulty in confirming the proper owner of the asset and agreed that had there been formal channels of communication between GWW and VicRoads, repair of the leak would have likely occurred in a timelier manner. However, GWW's "*firm view is that a significant degree of responsibility lay with VicRoads, as owner of the asset. Any adverse comment which her Honour considers making should be appropriately moderated in light of these facts*".

80. I agree that GWW was not solely responsible for repairing the asset. GWW also noted that it is open to working with VicRoads to establish a shared asset register, in order to expedite

communication in relation to asset management and maintenance. I further agree that this is a sensible and practical solution to the problem that occurred in this case.

Department of Transport (VicRoads) response

81. The Court provided the responses of both Winslow and GWW to the Department of Transport (**DTP**), as the Department responsible for VicRoads, together with a draft copy of my proposed findings.

82. DTP noted the submissions of both Winslow and GWW and explained that in 2018, VicRoads had two mechanisms for any road user, emergency service, government agency or contractor to raise issues:

    a) The Traffic Operations Centre (**TOC**) (then-called the Traffic Management Centre) which operates 24 hours per day, seven days per week. The TOC is contactable on 13 11 70.

    b) Submission of an online form for non-urgent hazards.

83. Since about October 2018, there has been an additional phone number (13 37 78) which is available from Monday to Friday, 8am to 6pm.

84. I accept that these numbers were and are available for any member of the public to contact VicRoads (or DTP), however the availability of a phone number or online form does not overcome the difficulties faced in this situation, namely, the delays in establishing ownership of the faulty asset and organising repairs for same.

85. DTP further submitted that it is currently developing a sustainable asset data collection strategy, which will include identification of fire hydrants that are owned and maintained by DTP. DTP explained that requirements for asset data information capture have been defined as part of the Victorian Transport Digital Engineering (**VTDE**) program. These requirements are being implemented to ensure that assets owned by DTP (including fire hydrants) are stored in DTP asset databases.

86. This appears to be a positive step; however, it is unclear how this data collection strategy will address the specific issue faced in this case. I therefore intend to recommend that DTP works with all water authorities in Victoria to establish a shared asset register, to expedite communication in relation to asset management and maintenance. The asset register should be owned and maintained by DTP and should be accessible to all water authorities in Victoria.

FINDINGS AND CONCLUSION

87. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Bikram Dangol, born 13 January 1988;

    b) the death occurred on 26 July 2018 on the Western Ring Road & M80 & M1 on-ramp, Laverton North, Victoria, 3026, from head and neck injuries in a motorcycle incident; and

    c) his death occurred in the circumstances described above.

88. Although I am unable to find that Mr Dangol's death was entirely preventable, I find that there were missed opportunities when GWW and VicRoads failed to escalate or address the water leak issue in a timely manner, which may have mitigated the risk of an accident occurring.

I convey my sincere condolences to Mr Dangol's family and loved ones for their loss.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That the **Department of Transport and Planning** consider working with all water authorities in Victoria to establish a shared asset register.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Bina Rajthala, Senior Next of Kin (C/- Zaparas Lawyers)

Greater Western Water (formerly City West Water)

Department of Transport and Planning

Major Roads Project Victoria (C/- Clayton Utz)

Transport Accident Commission

Ms Karen Macdonald, VicRoads

Winslow Construction Pty Ltd

Senior Constable Katelyn Carlton, Coroner's Investigator

Signature:

Coroner Kate Despot

Date : 09 April 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.