IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001679

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Andrew James Lack
Date of birth:	15 August 1964
Date of death:	4 April 2019
Cause of death:	1(a) INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (DRIVER)
Place of death:	886 Warburton Highway, Seville East, Victoria, 3139
Keywords:	Motor vehicle collision, criminal proceedings

INTRODUCTION

1. On 4 April 2019, Andrew James Lack was 54 years old when he died in a multi-vehicle motor vehicle accident. At the time of his death, Andrew lived at 52 Glenwright Avenue, Woori Yallock with his life partner Mara Herzog.

THE CORONIAL INVESTIGATION

2. Andrew's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Andrew's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Andrew James Lack 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]

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[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.

7. In considering the issues associated with this finding, I have been mindful of Andrew's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

8. On 5 April 2019, Andrew James Lack, born 15 August 1964, was visually identified by his brother, Philip Lack.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

10. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination on 5 April 2019 and provided a written report of her findings dated 6 May 2019.

11. Toxicological analysis of post-mortem blood and urine samples did not identify the presence of any alcohol, unlawful drugs or poisons.

12. Dr Francis provided an opinion that the medical cause of death was 1(a) injuries sustained in a motor vehicle collision (driver).

13. I accept Dr Francis's opinion.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

14. Mr Lack worked full time as a forklift driver in Kilsyth and was on his way to work at the time of the collision. He held a valid Victorian driver's licence[2] and had been driving for more than 30 years.

15. On Thursday 4 April 2019 at 5:22 am, a white Toyota HiAce van driven by Mr Jayden Riggall was travelling east along the Warburton Highway in Seville East. At the same time, a silver Holden Astra driven by Mr Lack was travelling west along the Warburton Highway with a white Isuzu D-Max utility driven by Mr Mark Hayden travelling close behind.[3]

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[2] VicRoads certificate under section 84(1), Coronial Brief

[3] Statement of Mark Hayden, Coronial Brief.

16. For an unknown reason,[4] Mr Riggall's van crossed to the incorrect side of the road and collided head-on with Mr Lack's car. Mr Hayden took immediate evasive action but the force of the collision between the other two vehicles caused the van to rotate clockwise and impact the passenger side of his utility.[5]

17. The collision occurred on the section of the highway between Old Warburton Highway and Sunnyside Road, directly outside 888 Warburton Highway.[6] This section of the highway is a three-lane road running generally east-west, and is constructed of sealed bitumen in good condition with gravel shoulders. The road is marked with white paint and has a single lane for vehicles travelling east, but two lanes for vehicles travelling west. The line closest to the centre is an overtaking lane, the design of which is responsive to a mild incline in the road at this point. There is a double solid white line dividing the eastbound traffic from the westbound traffic.

18. There is no lighting on the road, and at this time of day, at this time of year, the visibility conditions would have been that of night time, with the moon not rising until after 6 am. The road was dry.[7]

19. The posted speed limit is 90 kilometres per hour.[8]

20. Mr Hayden described the moments before the collision as follows:

> *As soon as the overtaking lane emerged I got into the right lane and began overtaking the cars in front… I was travelling at 90 km/h and the Astra [car] was doing about 80-85 km/h as I was slowly gaining on it… the next thing I remember seeing is a van that was travelling in the opposite direction coming towards us suddenly steered right over the double white lines into my lane and into the left lane in front of the Astra.*[9]

21. Witnesses and local residents immediately came to help, and emergency services arrived shortly thereafter.[10]

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[4] Mr Riggall elected to remain silent during the criminal investigation.
[5] Statement of Mark Hayden, Coronial Brief.
[6] Statement of DLSC Lauren McNiece, Coronial Brief.
[7] Statement of DSC Melanie MacFarlane, Coronial Brief.
[8] Statement of LSC Aidan Williams, Coronial Brief.
[9] Statement of Mark Hayden, Coronial Brief.
[10] Statement of Erin White, Coronial Brief.

22. Mr Lack succumbed to his injuries at the scene of the collision. Mr Hayden and Mr Riggall were taken to Maroondah Hospital. All three drivers had been travelling alone.[11]

23. Mr Riggall provided a sample of his blood pursuant to section 56 of the Road Safety Act 1986. This sample was analysed by the Victorian Institute of Forensic Medicine and it was determined that the sample did not contain any drugs or alcohol.[12]. He had no history of prior traffic offences.

24. Each of the vehicles was subsequently inspected. None of them were found to have any relevant defects, and from the position of the light control switches, it appeared most likely that all vehicles were travelling with their lights on.[13]

25. Examination of call charge records showed no phone use at the time of the collision.[14]

26. The reconstruction expert estimated that the speed of the van at the time of impact was between 82 and 86 kilometres per hour, and that the point of impact was 3.2 metres over the double white lines into the westbound lanes at the time of the collision.[15] She further estimated that Mr Lack was travelling at approximately 83 to 90 km/h, wholly within the appropriate lane.[16]

OTHER INVESTIGATION

27. On 13 December 2021, Jayden RIGGALL was acquitted of a single charge of Dangerous Driving Causing Death by way of jury verdict. As a result, the criminal matter is now complete.

FINDINGS AND CONCLUSION

28. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[17] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made

[11] Statement of LSC Aidan Williams, Coronial Brief.
[12] Statement of SC Nathan Martin, and Exhibits 6 & 7, Coronial Brief.
[13] Statement of SC Brett Gardner, Coronial Brief.
[14] Statement of DSC Brendan Eames-Mayer, Coronial Brief.
[15] Statement of DSC Melanie MacFarlane, Coronial Brief.
[16] Statement of DSC Melanie MacFarlane, Coronial Brief.
[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Andrew James Lack, born 15 August 1964;

    b) the death occurred on 04 April 2019 at 886 Warburton Highway, Seville East, Victoria, 3139, from INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (DRIVER); and

    c) the death occurred in the circumstances described above.

COMMENTS

30. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

    a) Having considered all of the evidence, I am satisfied that the collision was not caused by Mr Lack nor Mr Hayden.

    b) I am further satisfied that Mr Riggall caused the collision by failing to prevent his van from steering into the oncoming traffic.

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

Pursuant to section 73(1B) 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:

Mara Herzog, Senior Next of Kin

Mark Heydon, Witness

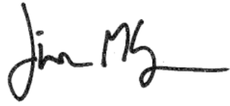
Christie Chessells, Transport Accident Commission

Claire Goodall, Transport Accident Commission

Jamie Hoffmann, Elders Rural Services

Sergeant Brendan Eames-Mayer, Coroner's Investigator

Signature:



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Coroner Simon McGregor

Date : 31 August 2023

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.