IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3638

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:	Kyle James Shepherd
Date of birth:	21 March 1989
Date of death:	7 July 2020
Cause of death:	1(a) Head and neck injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	Nevinson Road, Lockwood, Victoria

INTRODUCTION

1. On 7 July 2020, Kyle James Shepherd was 31 years old when he was fatally struck by a car. At the time of his death, Mr Shepherd lived at Lockwood with his family.

THE CORONIAL INVESTIGATION

2. Mr Shepherd'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. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Shepherd'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 Mr Shepherd's death, 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]

[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.

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

Identity of the deceased

7. On 17 July 2020, Kyle James Shepherd, born 21 March 1989, was identified via DNA comparison.

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

Medical cause of death

9. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 8 July 2020 and provided a written report of his findings dated 22 July 2020.

10. The post-mortem examination revealed significant injury to the head.

11. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Head and neck injuries sustained in a motor vehicle incident (pedestrian)"*.

12. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

13. Mr Shepherd lived with his parents and brother in Lockwood. He was self-employed in computer design for various video gaming companies.

14. On 7 July 2020, Mr Shepherd enjoyed a shopping trip in Kangaroo Flat with his family. His mother and sister wanted to continue shopping so Mr Shepherd and his father, Ronald Shepherd, made their way home.

15. Mr Shepherd returned home with his father at approximately 5.40pm. As their vehicle stopped at the front gate of their home, Mr Shepherd exited the car and told his father that he was going for a walk. While this was a normal activity for his son, Mr Shepherd Senior expressed concern that it was too late and too dark to go for a walk and he noted his son was wearing dark clothes. Mr Shepherd said to his father, *"no, it will be right"*. With that, he put his headphones on and walked off towards Nevinson Road.

16. That evening, the sun set at 5.14pm.

17. At approximately 6.00pm, Mr Shepherd was walking north along the western side of Nevinson Road in Lockwood.

18. Nevinson Road was a two-way, unmarked, unsealed road, that runs in a north south direction. The default speed limit was 100 kilometres per hour. There was farmland on both sides of the road. There was no shoulder to the road and there was an uneven and rough grass bank on each side. The road consisted of a single lane but it was wide enough so that two vehicles could pass side by side without having to slow or pull off to the side of the road. There was no streetlighting, which meant Mr Shepherd was walking along the road in darkness. At the time of the incident, the weather was fine, but the road was damp due to recent rain.

19. At about this time, a road user driving a utility and towing a trailer drove north along Nevinson Road. He observed another vehicle approaching in the opposite direction. The utility had its high beam headlights on and as the other vehicle approached, the driver dipped his lights to low beam and moved to the left side of the road so that both vehicles could safely pass each other. He was travelling at approximately 60 to 80 kilometres per hour.

20. As the utility moved to the left, the driver collided with a pedestrian who he said just "*popped up*". He later stated to police that he did not see the pedestrian until he struck him. The pedestrian was later identified as Mr Shepherd who was wearing dark clothing and headphones.

21. The driver was unable to avoid Mr Shepherd and collided with him. The driver immediately stopped his utility and contacted emergency services. The driver of the other vehicle appears to have been unaware of the collision and continued driving south.

22. Mr Shepherd suffered significant injuries as a result of the collision. Ambulance paramedics attended the scene and declared him deceased at 6.30pm.

23. The driver of the utility was tested for alcohol and illicit drugs, both of which returned negative results. An inspection of the utility revealed minor damage to the passenger side headlight and front indicator. It was otherwise in roadworthy condition.

24. The Victoria Police Major Collision Investigation Unit and Forensic Services Department examined the scene. Detective Sergeant Robert Hay concluded that Mr Shepherd had been approximately 1.8 metres east of the western edge of the road in the travelling lane when he was struck by the utility. At the time of the collision, the utility was travelling at approximately 60 kilometres per hour. Based on his calculations, this meant that the driver would have

required 38 to 48 metres and undertaken a lateral movement of 0.5 metres to the right to avoid colliding with Mr Shepherd. However, based on calculations, Mr Shepherd would have been first visible to the driver when he was between 18 to 38 metres from the utility.

25. Detective Sergeant Hay therefore concluded that the driver of the utility was unlikely able to avoid colliding with Mr Shepherd.

FINDINGS AND CONCLUSION

26. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Kyle James Shepherd, born 21 March 1989;

(b) the death occurred on 7 July 2020 at Nevinson Road, Lockwood, Victoria, from head and neck injuries sustained in a motor vehicle incident (pedestrian); and

(c) the death occurred in the circumstances described above.

COMMENTS

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

1. There are descriptions in the coronial brief of witnesses previously seeing Mr Shepherd walking along Nevinson Road wearing headphones. One witness noted, *"This males [sic] road sense has [sic] was not the best because I had seen him walk in the middle of the road and he would not see or hear you until you were right up near him"*. Another witness noted, *"He was always hard to see as he always had dark clothing on. I feared he wasn't giving himself a chance to be seen and being hit by a car would be a possibility"*. A further witness stated that she often observed Mr Shepherd walk on the road about one to two metres from the left side and that he would walk in the same direction as the traffic, *"meaning he would have his back to the oncoming cars"*. On other occasions, she saw him walking in the centre of the road.

2. One of the witnesses also noted that Nevinson Road had recently been graded. Previously, the main width of the road was about a car and a half and the shoulders would drop away to the edges. This meant that vehicles travelling in opposite directions would have to slow down and pull to their left-hand side to pass safely. Since the grading, the road was wider, and the edges of the road had been pushed out to where the shoulders used to finish to allow two vehicles to pass without slowing down. The shoulders used to be used by pedestrians. But pedestrians

now had to walk to the edges of the road surface because the grass bank on either side of the road was too rough for people to walk along.

3. To my mind, there are several factors that contributed to the incident. These include:

   (a) the rural area of the incident, which did not provide a safe and separate area for pedestrians;

   (b) Mr Shepherd was wearing dark clothing at night in an unlit area, which meant other road users were less likely to see him;

   (c) Mr Shepherd wearing headphones, which meant it was unlikely he would have heard approaching vehicles; and

   (d) Mr Shepherd was walking with the flow of traffic, which meant he may not have been aware of traffic approaching behind him.

4. I note that there are various campaigns focussed on pedestrian safety. Pedestrian safety education begins in primary school when students take part in *Stop, Look, Listen, Think* lessons.[2] With those basics firmly established, mainstream pedestrian safety campaigns targeted to older children and adults focus on further safety mitigation strategies, such as those that tell us to *Stop Before You Cross* when walking near public transport[3] and *DON'T TUNE OUT: Stop, Look, Listen, Think*, which promotes safe use of electronic mobile devices when crossing the road.[4]

5. While these are appropriate and commendable, campaigns directed at improving pedestrian safety in rural areas appears to be lacking. This is despite the recent comparable number of pedestrian fatalities in metropolitan Melbourne and regional Victoria.

6. In 2020, 211 lives were lost on Victorian roads.[5] Of these, 30 were pedestrian fatalities – 17 occurred in metropolitan Melbourne and 13 occurred in regional Victoria.[6] Of the

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[2] See generally Road Safety Education Victoria at http://www.roadsafetyeducation.vic.gov.au.
[3] *Crossing Safely*, Public Transport Victoria at ptv.vic.gov.au/more/travelling-on-the-network/travelling-safely/crossing-safely/#pedestrian.
[4] *Don't Tune Out*, Pedestrian Council of Australia at https://www.walk.com.au/pedestriancouncil/page.asp.
[5] *Lives Lost – Annual*, Transport Accident Commission at https://www.tac.vic.gov.au/road-safety/statistics/lives-lost-annual.
[6] *Pedestrians*, Transport Accident Commission at https://www.tac.vic.gov.au/road-safety/road-users/pedestrians?drop=3.

13 fatalities that occurred in regional Victoria, two were female and 11 were male. The greatest age bracket was 70 and over, with four deaths.[7]

7. As at 15 June 2021, the number of pedestrian fatalities on Victorian roads has already reached 11.[8]

8. I acknowledge the Victorian Road Safety Strategy 2021-2030,[9] which aims to halve the number of road deaths and reduce serious injuries by 2030. Specific aims include ensuring all Victorians are safe and feel safe on and around our roads and embedding a culture of road safety within the Victorian community. One of the goals of the Strategy is to make remote and rural roads safe for all road users.

9. I particularly note the Strategy identifies use of mobile phones as distraction, including by pedestrians, as it impairs a person's ability to respond to risks.[10]

10. To this end, the Strategy recognises that road safety is complex and requires the cooperation of multiple government agencies and the Victorian community through, amongst other things, public information campaigns and education programs. The Strategy acknowledges that to be most effective, these need to be targeted and tailored to sub-groups.[11]

11. I accept that road safety requires a multi-pronged effort across the Victorian government and requires road users to engage in behaviour modification to recognise and respond to perceived and actual risks. In order to specifically reduce pedestrian fatalities in rural areas, a number of state government and local government agencies will need to work together to encourage pedestrian safety and educate pedestrians about the risks of walking along rural roads. I will make recommendations to this effect.

RECOMMENDATIONS

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

1. With the aim of reducing pedestrian fatalities through education focussing on the safe use of shared roads in rural areas, I recommend that the **Department of Transport** and **Transport**

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[7] Search conducted using the *Search Statistics* function at Transport Accident Commission https://www.tac.vic.gov.au/road-safety/statistics/online-crash-database/search-crash-data?collection=tac-xml-meta&form=simple.
[8] *Lives Lost – Year to Date,* Transport Accident Commission at https://www.tac.vic.gov.au/road-safety/statistics/lives-lost-year-to-date.
[9] Available at https://www.tac.vic.gov.au/__data/assets/pdf_file/0020/502166/RoadSafetyStrategy_DEC2020.pdf.
[10] See page 18 of the *Victorian Road Safety Strategy 2021-2030.*
[11] See pages 40 to 41 of the *Victorian Road Safety Strategy 2021-2030.*

Accident Commission work with other relevant state government departments and agencies to specifically develop education campaigns directed at pedestrians in rural areas.

2. With the same aim, I recommend that the **City of Greater Bendigo** consider developing and implementing a local education campaign directed at pedestrians in its catchment area.

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

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:

Ronald and Jennifer Shepherd, senior next of kin
The Hon Ben Carroll MP, Minister for Roads and Road Safety
Paul Younis, Secretary, Department of Transport
Joe Calafiore, Chief Executive Officer, Transport Accident Commission
Craig Niemann, Chief Executive Officer, City of Greater Bendigo
Paul Northey, Chief Regional Roads Officer, Regional Roads Victoria
Senior Constable Dale Andrews, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 25 June 2021

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 six 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.