IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001712

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr V
Date of birth:	[redacted] 1991
Date of death:	3 April 2021
Cause of death:	*Neck injury*
Place of death:	Rifle Butts Road, Whoorel, Victoria, 3243

INTRODUCTION

1. Mr V,[1] born [redacted] 1991, was 29 years old at the time of his death. He is survived by his mother, [redacted], his partner, [redacted], and his son, [redacted].

2. Mr V was involved in a motorbike accident at a young age and was later diagnosed with osteo-arthritis and chronic back pain. His general practitioner noted that he was suffering from a disc prolapse and mild degenerative changes of his right hip for which he was prescribed amitriptyline, naproxen, and orphenadrine.

3. [redacted] described Mr Vas a *very good driver* but stated that he *did like to speed* and was a *bit of a hoon*. He held a current Victorian Driver's Licence and had previously had his licence suspended for three months in 2019 for speeding offences.

4. On 3 April 2021, Mr V died as a result of a neck injury sustained in a motor vehicle collision on Rifle Butts Road, Whoorel.

THE CORONIAL INVESTIGATION

5. Mr V's death was reported to the Coroner as it appeared to fall within the definition of a reportable death in the Coroners Act 2008 (Vic) (**the Act**). A reportable death includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury.

6. A coroner independently investigates 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. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

7. 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

[1] Referred to as 'Mr V' unless more formality is required.

[2] 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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Senior Constable Johan Wisewould (**SC Wisewould**) to be the Coroner's Investigator for the investigation into Mr V's death. SC Wisewould conducted inquiries on my behalf, including taking statements from witnesses and compiling a coronial brief of evidence. The brief comprises statements from Mr V's family members, responders to the collision, emergency services who attended the incident, Mr V's treating practitioner, the forensic pathologist who examined him, as well as other relevant documentation.

9. I have based this finding on the evidence contained in the coronial brief.

10. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required. 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.

Background

11. On 1 April 2021, Mr V, [redacted] and [redacted] went on a holiday to the Warrnambool Discovery Park. They had arranged to stay there until 4 April and drove there in [redacted]'s 2005 Holden Commodore sedan, registration [redacted], which Mr V had serviced the previous month. The following day, the family went sightseeing around Portland before returning to their room that evening.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 3 April 2021, the group travelled to Lorne via the Great Ocean Road with Mr V driving. They were unfamiliar with the area and were using [redacted]'s phone GPS function to navigate them down Rifle Butts Road during the return trip. [redacted] stated that Mr V began accelerating *as anyone else would* as they drove along the road however, she stated that she was unable to recall the exact speed that Mr V was going prior to the collision.
13. At approximately 2.20pm, the Commodore encountered a dip in the road which [redacted] described as *scary* and feeling like a *roller coaster ride*. The vehicle became airborne for approximately 26 metres before impacting back on the road surface. Following the impact, Mr V lost control of the Commodore which rotated in anti-clockwise direction and collided with a farm fence on the side of the road before rolling and coming to rest on its roof approximately 195 metres from the road in an adjacent farming paddock.

14. [redacted] stated that she *woke up out of the car* but could not recall how she managed to extricate herself from the wreck. At 2.30pm, near-by residents attended to the incident after receiving a Vic Emergency Alert of the collision. On arrival, they found [redacted] standing near the road, with [redacted] and Mr V still inside the vehicle.

15. The responders managed to retrieve [redacted] from the vehicle who was not seriously injured, likely as a result of his five-point harness which he was wearing during the journey. The responder then checked on Mr V who was trapped in the vehicle however he was found to be unresponsive and did not have a pulse.

16. Emergency services attended the incident at 2.46pm and confirmed that Mr V was deceased. [redacted] and [redacted] were then conveyed to hospital with non-life-threatening injuries.

Rifle Butts Road

17. Rifle Butts Road, Whoorel, is a two-way bitumen road travelling in an east-west direction with a single lane for traffic in each direction. The road is undivided and lane markings are present at either end of the road. It has a default speed limit of 100km/hr. The surface varies from good to poor condition along the length of the road, with an unpaved shoulder consisting of dirt and grass, and is bordered by farming paddocks.

18. At the location where the collision occurred, there is a steep decline in the road approximately five kilometres from the western entrance. At this section, there are two lanes separated by double white lines. Guttering and safety railing borders the road during the descent. There is a dip in the road that is approximately 21 metres long, is approximately 70 mm in depth, and has a sunken road appearance.

19. Records from Colac Otway Shire Council indicate that frequent maintenance and repairs were conducted on Rifle Butts Road during the 2020 – 2021 period, however these predominantly pertain to pothole repairs and breaks in the road edge with temporary speed reductions. I note that none of the recorded maintenance repairs pertained to the dip itself.

Police investigation

20. Detective Senior Constable Melanie MacFarlane (**DSC MacFarlane**) of the Victoria Police Forensic Services Department reviewed the circumstances of the collision and provided a report dated 30 April 2021.

21. DSC MacFarlane noted the presence of scratch marks in the road surface at the base of the large hill. These were consistent with scratch marks observed on the undercarriage of the Commodore driven by Mr V at the time of the incident, indicating that the vehicle's suspension had 'bottomed out' after impacting the road surface, the resulting force likely contributing to a loss of control and subsequent collision.

22. A reconstruction of the incident conducted by Victoria Police demonstrated that a vehicle, travelling at 100km/hr, became airborne after encountering the dip in the road for six to 10 metres before returning to the road surface.

23. DSC MacFarlane also noted that the presence of tyre marks at the scene of the collision were consistent with the Commodore having been oversteered following the impact, resulting in it rotating in an anti-clockwise direction before impacting the fence post and rolling.

24. DSC MacFarlane further calculated that Mr V's vehicle was travelling in a westerly direction at a speed between 104 and 116 km/hr at the time of the collision, however DSC MacFarlane was unable to determine the speed of the vehicle whilst it was travelling downhill.

25. Senior Constable Brett Gardner **(SC Gardner**) of the Victoria Police Collision Reconstruction Mechanical Investigation Unit conducted a mechanical inspection of the Commodore and provided a report dated 30 May 2021.

26. SC Gardner's examination of the vehicle did not reveal any mechanical faults, failures, or conditions that would have caused or contributed to the collision.

27. SC Wisewould concluded that there were several contributing factors to the collision, including Mr V's unfamiliarity with the area, the construction of Rifle Butts Road and its poor condition, and the speed of the vehicle prior to the fatal collision. SC Wisewould noted that the dip in the road would not have been visible to Mr V who was unaware of its presence and therefore, could not have known to approach the area with caution.

IDENTITY

28. On 7 April 2021, [redacted] visually identified Mr V, born [redacted] 1991, whom he had known for 29 years.

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

CAUSE OF DEATH

30. On 8 April 2021, Dr Joanna Glengarry, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy and provided a written report dated 10 May 2021.

31. The autopsy revealed a high cervical spinal injury, as well as other traumatic injuries. Dr Glengarry noted that this particular injury may be associated with significant damage to vital centres within the spinal cord and has a high mortality rate.

32. Dr Glengarry observed that there was no significant natural disease and, in particular, no evidence of cardiac disease.

33. Dr Glengarry concluded that a reasonable cause of Mr V's death was from a '*neck injury*'.

34. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

35. I accept Dr Glengarry's opinion

FINDINGS AND CONCLUSION

36. After reviewing the available evidence, I agree with SC Wisewould's conclusions regarding the probable cause of the fatal collision. Mr V and [redacted] were not locals to the area and were therefore unfamiliar with the road's condition and need for caution when descending that particular section of road.

37. As already noted, Mr V's vehicle was travelling in a westerly direction at a speed between 104 and 116 km/hr at the time of the collision, but the speed of the vehicle whilst it was travelling downhill was unable to be determined. The Coroner's investigator however concluded that Mr V is likely to have approached the dip at a speed greater than the speed limit of 100 km/hr, noting that the speed at which Mr V was travelling was fast enough for the vehicle to travel approximately 26 metres whilst airborne, compared to approximately 6 to 10 metres of the police vehicle travelling at 100 km/hr.

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

    a) the identity of the deceased was Mr V, born [redacted] 1991;

    b) the death occurred on 3 April 2021 on Rifle Butts Road, Whoorel from a *neck injury*; and

c) the death occurred in the circumstances described above.

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

RECOMMENDATIONS

40. During the course of his investigation into the cause of Mr V's death, SC Wisewould identified several improvement opportunities in regard to the state of Rifle Butts Road (at the time of the incident). After reviewing these suggestions, I consider they represent valid prevention opportunities.

41. Therefore, pursuant to section 72(2) of the Act, I make the following recommendations:

(i) *Hazard/warning signage should be installed at the relevant section of Rifle Butts Road, Whoorel pending elimination of the dip, described by investigators as a sunken part of the road surface approximately 21 metres long.*

(ii) *Colac Otway Shire investigate the cause of the dip in the road and make repairs to eliminate the dip.*

(iii) *Permanent hazard/warning signage should be installed at the relevant section of road should the dip become a recurring issue following the repairs.*

(iv) *The speed limit for the relevant section of road, including the lead-up to the crest, should be reduced.*

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

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

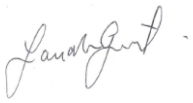
[redacted] **Senior Next of Kin**

[redacted]

Colac Otway Shire

Senior Constable Johan Wisewould, Victoria Police, Coroner's Investigator

Signature:



SARAH GEBERT

CORONER

Date : 30 May 2022

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.