



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002375

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Bailey Peer Harry
Date of birth:	19 April 1996
Date of death:	6 May 2021
Cause of death:	1(a) Multiple injuries sustained in a bicycle incident (rider)
Place of death:	Alfred Health, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Collision, 40km speed zone, car vs cyclist, lack of protective gear, speed, basis for DPP notification

Aboriginal and Torres Strait Islander readers are respectfully advised that this content contains the name of a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 6 May 2021, Bailey Peer Harry¹ was 25 years old when he passed away following a collision in which he was riding a bicycle. At the time of his passing,² Bailey had a partner who described him as ‘happy’ and ‘madly crazy in love’. Bailey, a proud Wiradjuri man with strong connections to his culture, was a loving father to his three young children.
2. Bailey’s family describes him as being a young man with a huge heart – the ‘*jewel of the family, and the glue that held everyone together*’.

THE CORONIAL INVESTIGATION

3. Bailey’s passing 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.
4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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. 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.
6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Bailey’s passing. The Coroner’s Investigator conducted inquiries on the Coroner’s behalf and submitted a coronial brief of evidence.

¹ Referred to throughout my finding as ‘Bailey’, unless more formality is required.

² The term ‘passing’ is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (see ‘Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying’, Queensland Government, December 2015, available [here](#)). I will therefore use the term ‘passing’ in this finding, save where I am required to use the word ‘death’ as used in the *Coroners Act 2008*.

7. A colleague held carriage of the investigation into Bailey's passing, until it came under my purview in July 2023 for the purposes of furthering the investigation, gathering additional evidence and making findings.
8. This finding draws on the totality of the coronial investigation into Bailey's passing, 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.³

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

Circumstances in which the death occurred

9. At about 6.40pm on 6 May 2021, a 22-year-old man (**the driver**) was driving with his partner southbound on Drummond Street, Oakleigh. The driver estimated that he was travelling at about 40 km/h. At the same time, Frank Pettinato (**Mr Pettinato**) was driving his vehicle on Logie Street, Oakleigh in a westerly direction, approaching the T-junction with Drummond Street where Logie St ended. Mr Pettinato noticed a young man on a bicycle travelling quickly, also in a westerly direction, on the footpath of Logie Street to his left. The man was wearing a black hooded jumper with the hood up over his head, shorts, no helmet and did not have any lights installed on his bicycle.
10. As the cyclist approached the T-junction with Drummond St, Mr Pettinato noted that he did not appear to slow down and did not look left or right to check for traffic and give way. He also noted the driver's vehicle approaching the T-junction and estimated he was travelling at about 60km/h. He saw the cyclist continue to travel straight into Drummond St without looking.
11. The driver's vehicle was travelling straight on Drummond St and had right of way. The cyclist travelled into Drummond St from the footpath of Logie St and the path of the driver's vehicle. The driver was unable to brake or swerve to avoid the collision.

³ 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.

The cyclist hit the bonnet and windshield of the driver's vehicle and was thrown from the bicycle, landing to the right of the vehicle on his back.

12. Assistance was rendered to the cyclist, who was unconscious and bleeding. The driver's partner called '000' and relayed information from the '000' call-taker to the driver and Mr Pettinato.
13. Victoria Police and Ambulance Victoria arrived on scene at about 7.00pm and commenced cardiopulmonary resuscitation on the cyclist. He was taken by ambulance to the Alfred Hospital in a critical condition. Despite the best efforts of paramedics, he was declared deceased upon arrival at the Alfred Hospital. He was subsequently identified as Bailey Peer Harry.
14. The driver was required to undergo a preliminary breath test and was conveyed to hospital to provide a sample of his blood. The tests established that he was not under the influence of alcohol or illicit substances at the time of the incident.
15. Logie Street, before the intersection with Drummond Street, is a dual carriageway, with the traffic travelling in opposite directions separated by a grass median strip. Drummond Street is a single carriageway, its lanes separated by a broken white line. The speed limit applicable to that part of Drummond Street is 40km/h. Logie Street has 'give way' signs erected at its intersection with Drummond Street. Both streets are of bitumen construction and are in good condition with no potholes or other obvious signs of wear. At the time of the collision, it was dark but streetlights were illuminated, the road surface was dry, the weather was fine, and the visibility was good.
16. As part of the investigation, Victoria Police inspected the driver's car and Bailey's bicycle. The driver was driving his 2012 black Ford Falcon sedan (**the Falcon**). The Falcon had impact damage to the front bumper, bonnet, and front windscreen. No brake marks were identified on the road to indicate that the vehicle had significantly braked before the collision. No faults were identified with the Falcon's brakes or tyres that would have prevented it from braking. While not subject to a formal mechanical inspection, the Falcon was found to be in a roadworthy condition and was not found to have any faults that could have caused or contributed to the collision.
17. Bailey's bicycle was a red BMX-style bicycle and was found to have impact damage to the right-hand side and wheel assembly, with a metal pedal missing. The bicycle

had no reflective markers or lighting systems, and the front left hand brake cable was severed at the rear brake assembly. The front and rear tyres were in adequate condition, though the front tyre's tread was worn. Police concluded that the bicycle had no real braking capability and Bailey would have had to either "*jam*" his foot into the rear wheel or use the base of his foot to place pressure on the ground and utilise friction to slow himself down. Police opined that even if Bailey had seen the driver, he may not have been able to effectively slow down or come to a stop in time to avoid the collision.

18. Detective Sergeant (**D/Sgt**) Jenelle Hardiman of the Collision Reconstruction Unit, Victoria Police, investigated the information provided from the collision scene and provided a report (**Collision Reconstruction Report**). She calculated that Bailey was thrown about 10.9m upon colliding with the Falcon and the bicycle was thrown about 31.5m from the location of impact. The Falcon came to a stop with the rear of the vehicle about 15.4m from the area of impact. D/Sgt Hardiman estimated that the Falcon was travelling between 45km/h and 65km/h at the time of impact. However, it was not known whether Bailey's bicycle was moved before police arrived on scene, which may have impacted the accuracy of subsequent calculations.
19. Police concluded that the collision of the driver's car with Bailey's bicycle was unavoidable. Bailey's inattention to the traffic on Drummond St, failure to give way, lack of appropriate safety equipment, and potential drug intoxication were identified as contributing factors in the collision.
20. Police were of the opinion that, even having regard to the estimates of speed in this case, the driver's driving was not dangerous in the circumstances by reference to speed alone. No charges were laid against the driver.

Identity of the deceased

21. On 11 May 2021, Bailey Peer Harry, born 19 April 1996, was visually identified by his brother.
22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Forensic Pathologist Dr Melanie Archer (**Dr Archer**), from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 7 May 2021, and provided a written report of her findings dated 3 June 2021.
24. The post-mortem examination revealed comminuted fractures to the bones of the right side of the skull extending to its base,⁴ fractures of thoracic and lumbar vertebrae and bilateral pneumothorax.⁵ The findings were consistent with the reported incident of a bicycle collision with a motor vehicle and a subsequent fall onto the road.
25. The post-mortem CT scan also revealed a large of number of ovoid hyperdensities embedded in the right thigh with an appearance highly suggestive of shotgun pellets, and two pellets also potentially embolised to the right lung. Dr Archer explained that there was no evidence on external examination of any recent gunshot injury and scarring present on the right thigh suggested it was associated with an incident in the past.
26. Toxicological analysis of post-mortem blood samples identified the presence of methylamphetamine⁶ and delta-9-tetrahydrocannabinol,⁷ but no alcohol or other commonly encountered drugs or poisons.
27. Dr Archer provided an opinion that the medical cause of death was “*1(a) Multiple injuries sustained in a bicycle incident (rider)*”.
28. I accept Dr Archer’s opinion.

FAMILY CONCERNS

29. In 2023 and 2024, Bailey’s family submitted a number of concerns to the Coroners Court of Victoria (**the Court**) regarding the circumstances of the collision in which Bailey was killed, and the police investigation that ensued. In particular, it was submitted on behalf of Bailey’s family that:

⁴ The cranial fractures involved the right temporal, parietal, and occipital bones with extension of the fracture line over the vertex to the left, forming a left petrous temporal base of skull fracture. Dr Archer also noted pneumocephalus (the presence of air within the cranial cavity).

⁵ A pneumothorax is a collapsed lung which occurs when air leaks into the space between the lung and chest wall.

⁶ Amphetamines is a collective word to describe central nervous system (**CNS**) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as *speed* or *ice*.

⁷ Delta-9-tetrahydrocannabinol (**THC**) is the active form of cannabis (marijuana).

- a) Due weight was not given by police either at the time of the collision, nor during the police investigation, to Mr Pettinato's eyewitness evidence that the driver of the Falcon was speeding;
- b) Due weight was not given to evidence of speeding contained in the Collision Reconstruction Report;
- c) Police did not consider (adequately or at all) evidence of the driver's unlawful speed when considering whether an indictable offence may have been committed – both prior to and after receiving the Collision Reconstruction Report – and police discretion to charge may not have been exercised (adequately or at all); and
- d) It is therefore appropriate that the matter be brought by the Coroner to the attention of the Director of Public Prosecutions (**DPP**) so that it might be fully and properly investigated. In this connection, it is submitted that section 49(1) of the *Coroners Act 2008* is a mandatory provision requiring the Court to notify the DPP if the Coroner investigating the death believes an indictable offence may have been committed in connection with the death, with the test for a mandatory referral to the DPP not being a high one – the Court need only be of the belief that an indictable offence *may* have been committed.

30. Bailey's family also submitted there were deficiencies in the immediate management of the collision site and subsequent investigation, including that police protocols meant that the Major Collision Investigation Unit (**MCIU**) ought to have attended the collision, which did not occur. It was further submitted that the police investigation focused unduly on Bailey's conduct, disregarding that of the driver.

SUBSEQUENT INVESTIGATIONS

31. Having received Bailey's family's concerns, and in order to: (i) effect a comprehensive investigation in accordance with my obligations to pursue all reasonable lines of inquiry;⁸ (ii) assist in making findings under section 67(1) of the Act; and (iii) explore the need for any comments, recommendations or a referral under s49(1) of the Act, I

⁸ *Priest v West* (2012) 40 VR 521 (*Priest v West*) is relevant to this obligation insofar as it enshrines the well-established principle that, in investigating a death, the coroner must pursue all reasonable lines of enquiry, be an active investigator and discover all they can about the circumstances surrounding the death (at [521], [525] and [560]).

deemed it appropriate to conduct a number of additional investigative steps. Namely, I obtained:

- a) Additional materials from the Coronial Investigator, including, among other things, notes of attending police members and email correspondence from Sergeant Sam Howie of the Nunawading Highway Patrol (**Sgt Howie**);
- b) A supplementary Collision Reconstruction Report from D/Sgt Jenelle Hardiman; and
- c) A response from Monash City Council (**the Council**) to confirm online reports I had seen of a trial by the Council of a reduced 30km/hr speed limit on Drummond Street, Oakleigh, due to reported concerns about speeding and hooning activity on this street, and whether any action had been taken in response.

32. I will address these additional materials in turn.

I. Further correspondence from Sergeant Howie

33. The email correspondence from Sgt Howie addresses certain issues of concern expressed on behalf of Bailey's family relating to the police investigation. Therein, Sgt Howie noted:

- a) Criminal matters are always considered by police in all circumstances involving a death;
- b) Sgt Howie, himself a former detective at the MCIU, attended the scene of the collision and liaised with various members of the MCIU that evening, and it was determined that MCIU attendance was not required;
- c) An initial determination was made that, regardless of whether the driver of the Falcon was travelling at 40 or 60km/hr, the driver would not have had an opportunity to react to the cyclist failing to give way and entering the intersection, noting that it was dark when the collision occurred and that there were no brakes nor lights on the bicycle, and that the cyclist was not wearing a helmet, had no high visibility clothing, and was travelling at speed;
- d) The offences of 'dangerous driving causing death' and *Road Safety Act 1986* and related Regulations offences were considered, but Sgt Howie did not at the time form the belief on reasonable grounds that an indictable offence had been committed by the driver, and maintained that belief upon receipt of the

Collision Reconstruction Report and post-collision toxicological results for the driver; and

- e) In order to proceed with criminal charges related to the speed of the Falcon, Sgt Howie would be required to use the lowest speed in the estimated range of 45-65km/hr, and speed alone would not constitute dangerous driving causing death in the circumstances.

II. Supplementary Collision Reconstruction Report

- 34. Having considered this correspondence, and noting that Bailey's family maintained concerns in relation to the circumstances and investigation of the collision (including about the speed of the Falcon), I determined it appropriate to obtain a supplementary report from D/Sgt Jenelle Hardiman (**Supplementary Collision Reconstruction Report**), which was provided on 29 October 2024.
- 35. Therein, D/Sgt Hardiman maintained that the contents of the original Collision Reconstruction Report were true and correct, and added a response to the following question posed by the Court: *'What, if anything, can you say about the degree of contribution of the driver's speed to the collision?'*
- 36. D/Sgt Hardiman opined, among other things, the following:
 - a) *'Reality is, there is no impact speed at which survivability can be assured. There are many variables in all crashes that affect injury severity including but not limited to speed, vehicle category, road user type, location of impact, and use of safety equipment. Speed is recognised as a key contributor to crash likelihood and injury severity and to road safety performance in general';*
 - b) At impact with the cyclist, the Falcon was travelling no less than 45 km/h but could have been up to 65km/h *'and most likely towards the higher end of the range';*
 - c) Survivability in the event of a collision is substantially higher when a cyclist is wearing a helmet, and *'if the vehicle had been travelling at the speed limit (40km/h) or less at impact and the cyclist had been wearing a helmet, I would not expect the cyclist to have sustained fatal injuries';*
 - d) However, if the vehicle had been travelling at the speed limit (40km/h) or less, even without a helmet, at 25 years of age, fatal injuries to the cyclist would be highly unlikely in a wrap trajectory.

37. D/Sgt Hardiman concluded that, in her opinion, *‘both the speed of the vehicle at impact and the fact that the rider was not wearing an approved safety helmet have both contributed to the death of the cyclist. Had the vehicle been travelling less than the speed limit, death would have been unlikely even without a helmet’*.

III. Monash City Council statement

38. In correspondence to the Court, the Monash City Council confirmed that, in 2023, it engaged an independent consultant to complete a study of trialling a potential 30km/h speed limit across the Oakleigh Activity Centre, including Drummond Street (encompassing the collision site), to address community concerns about hooning, speeding and pedestrian safety (**the Study**).
39. This Study recommended a 30km/h speed limit as a potential option. However, due to current Department of Transport and Planning regulations relating to the process and approval of 30km/h speed limits, the Study recommended that Council consider the implementation of physical traffic management treatments as an interim measure to reduce vehicle speeds, including along Drummond Street and Atherton Road (east of Atkinson Street/Hanover Road) (**Study Recommendations**).
40. The Council reported that, between 1 January 2019 and 31 December 2023, three recorded collisions occurred along Drummond Street, including the one involving Bailey. Two other collisions resulted in serious or other injuries, but no other fatalities occurred during this period.
41. The Council confirmed that the speed limit on Drummond Street varies by section. Between Dandenong Road and Atherton Road, the speed limit is set at a mix of 40km/h and 50km/h. North of Logie Street, the default urban speed limit of 50km/h applies while south of Logie Street the speed limit is 40km/h. The Council confirmed that the collision in which Bailey was killed occurred in a 40km/h school zone (though the collision occurred outside of school zone hours).
42. In response to the Study Recommendations regarding traffic management on Drummond Street, the Council indicated that it has not implemented any measures at this stage but has:

[...] referred this to its established process for prioritising physical traffic management interventions. This process ensures a balanced approach and allocation of Council resources between physical traffic management, education or enforcement interventions. Each year, Council staff review the priority list of local streets to assess the most appropriate intervention. Traffic counts are conducted to assess traffic speed profiles which assist staff to be more informed in the prioritisation and assessment process. If a street ranking is elevated Council may recommend a business case and seek funding through the annual budget planning process for physical traffic management interventions. Regarding Drummond Street after reviewing the current priority list, traffic management intervention is not considered a priority at this time. However, Council staff will continue to monitor the situation through annual reviews and traffic counts. If conditions change and Drummond Street is identified as a high priority, it will be referred to the budget planning and approval process for traffic management intervention.

NATURAL JUSTICE PROCESS

The driver

43. Given that the interests of the driver are engaged by: (i) the prospect of the exercise of the s49(1) notification provision (**Issue One**); and (ii) the evidence suggesting that the speed of the Falcon at impact contributed to the collision and its outcome, which gives rise to the potential for an adverse comment against the driver (**Issue Two**), I deemed it appropriate to provide the driver with an opportunity to respond to these two issues.
44. The Court corresponded with the driver via his original legal representatives on 24 December 2024, then again directly with the driver throughout 2025. Due to the driver being overseas and requiring time to seek new legal representation, the driver sought an extension of time in which to provide any response by 11 September 2025, which I granted. A response was received on 9 September 2025 in relation to Issue One. No response was received on Issue Two.

45. It was submitted on the driver's behalf in relation to Issue One *'that there is simply no evidence within the brief that could amount to this Court finding an indictable offence had been committed by [the driver]'*.⁹

Bailey's Family

46. In response to a letter from the Court noting that I considered I now had sufficient material to make findings without convening an inquest, and that I was considering an adverse comment regarding Bailey's conduct (namely that by riding at night a bicycle without reflectors, lights and a working brake and entering the intersection at speed from the footpath, and from a potentially obscured position, Bailey contributed to the collision, and that the failure to wear a bicycle helmet contributed to the severity of the injuries he sustained in the collision), the family submitted on 11 September 2025:

- a) The Court should make a finding that the driver's speed was the primary cause/circumstance of the death;
- b) A notification to the DPP is mandatory in the circumstances; and
- c) The proposed adverse findings against Bailey ought not be made, and if they are, they ought to be described as a circumstance and as secondary to the driver's speed as the primary cause/circumstance of the death.

CONCLUSION AS TO CONTRIBUTING FACTORS TO THE COLLISION

47. Having considered all the available evidence, and the submissions made on behalf of Bailey's family and the driver, I find that there were a number of factors that contributed to the collision and to Bailey's subsequent passing. Firstly, in entering the intersection, Bailey did not give way to the Falcon as required. Based on the available evidence, Bailey either did not look for oncoming traffic on Drummond Street at all, or he saw the Falcon too late to stop, considering the inadequate brakes on the bicycle. I note that the eye-witness account of Mr Pettinato is more consistent with Bailey not seeing the car at all.

⁹ The response continued: *'The only allegation of fault is that of alleged excessive speed. The only admissible evidence of speed is that of expert witness Hardiman. Eye witness's [sic] cannot give evidence of a vehicle's speed. Mr [sic] Hardiman's report, on a criminal standard, purports speed at 5km/h over the posted speed limit. That being the case the prosecution couldn't allege anything greater than 5km/h over such limit. Dangerous Driving requires the speed involved a "real danger" to the public in the vicinity such that the speed itself was intrinsically dangerous in all the circumstances. No indictable case could ever be founded on a 5km/h excess in speed'*.

48. Bailey was dressed in dark clothing, including with his black hood over his head, and the collision occurred at night. There were no lights or reflectors on Bailey's bicycle. He was described as travelling at a fast speed (though his speed is not quantified in the Collision Reconstruction Report), and the location from which he travelled was likely partially obscured from oncoming traffic on Drummond St due to vegetation growing at the location where the footpath of Logie St meets Drummond St. These are all factors contributing to the collision and to the fact that the driver did not have an adequate opportunity to see Bailey and brake prior to the collision.
49. However, I must consider, in this connection, that the evidence supports that the driver was speeding at the time of the collision – at least 5km/hr over the speed limit and likely higher.
50. I note that, while both the driver and his partner assert that the Falcon was travelling at the speed limit, which was 40km/h, the witness Mr Pettinato estimated that the Falcon was travelling at 60km/h. While the eyewitness accounts are relevant, I consider D/Sgt Hardiman's opinion, which involves detailed calculations based on validated methodology, to be the most reliable source of evidence of the speed of the Falcon.
51. D/Sgt Hardiman opined in the Collision Reconstruction Report that the Falcon was travelling between 45km/h and 65km/h at the time of impact. In the Supplementary Collision Reconstruction Report, D/Sgt Hardiman notes that, within this range, the speed of the driver was '*most likely towards the higher end of the range*'.
52. While this may at first blush appear not of great significance, D/Sgt Hardiman provided a persuasive opinion in her Supplementary Collision Reconstruction Report containing details of a study on speed-fatality probability relationships, illustrating the effect of impact speeds on severity of selected collision types. The risk of fatal injuries to a cyclist vis-à-vis the speed of a driver is stated as follows (reproduced in table format by the Family):

Speed	Description	Risk of fatal injuries to cyclist
40 km/hr	Driving at speed limit	30%
45 km/hr	Driving 5 km/hr above speed limit	60%
65km/hr	Driving 25 km/hr above speed limit	95%

53. It is therefore evident that, a driver exceeding the posted speed limit, even where such speed limit is at the lower end of the scale (e.g. 40km/hr) can result in significantly increased chances of death for a vulnerable road user such as a cyclist. D/Sgt Hardiman noted that, in the case of a wrap trajectory in which the cyclist was not run over after impact, it is unlikely that the cyclist would have sustained fatal injuries had the driver been travelling at 40km/hr or less.
54. I accept D/Sgt Hardiman's opinion and conclude that the speed of the driver was a factor contributing to the fatal collision, likely affecting the driver's inability to stop in time to avoid impacting Bailey when he entered the intersection.
55. D/Sgt Hardiman has also opined that Bailey's failure to wear an approved safety helmet contributed to the fatal outcome, though qualifies that had the driver been travelling at or under 40km/hr, even without a helmet, it is unlikely Bailey would have sustained fatal injuries.
56. I accept D/Sgt Hardiman's opinion, noting forensic pathologist Dr Archer's report which describes Bailey's catastrophic head injuries following the collision, and conclude that Bailey's failure to wear a helmet was a factor contributing to his passing.
57. I consider that the degree to which these two respective factors (speed of driver versus lack of helmet) contributed to Bailey's passing cannot be quantified with any real precision. D/Sgt Hardiman provides no such opinion. Indeed, these two contributory factors must be viewed alongside the other factors that contributed to the collision noted at paragraphs 47 and 48 above, including Bailey riding at night a bicycle without reflectors, lights and a working brake and entering the intersection at speed from the footpath, and from a potentially obscured position. All of these factors contributed to the collision and the conduct of both driver and rider played a role in the fatal outcome.
58. I note that Bailey's post-mortem toxicological blood analysis supports that Bailey had ingested methylamphetamine (ice) and cannabis at some point prior to the collision. In the absence of evidence (e.g. from a forensic physician) as to Bailey's degree of likely intoxication, or evidence about his habitual use, I have no sound basis to conclude, on the balance of probabilities, that intoxication was a contributing factor to the collision, though this is evidently a possibility.

THE LEGAL FRAMEWORK PERTAINING TO THE CORONER'S NOTIFICATION PROVISION

59. Section 49(1) of the *Coroners Act 2008* requires that the Principal Registrar notify the Director of Public Prosecutions if the Coroner investigating the death or fire believes an indictable offence may have been committed in connection with a death or fire.
60. This notification provision was described by then-State Coroner Judge Cain in his Finding into the Death of Gabriel Messo.¹⁰ Therein, his Honour stated:

The concept of belief has been variously expressed, it is however settled that it requires something more than suspicion, and is an inclination of the mind towards assenting to, rather than rejecting, a proposition, based on facts that are sufficient to create that inclination of the mind in a reasonable person (see George v Rockett (1990) 170 CLR 104).

The requisite threshold that I must attain has been expressed by the legislature as a 'belief that an indictable offence may have been committed'. This is not a belief, as submitted by Counsel Assisting, 'that it was committed, nor that a jury would find a person guilty of that offence or even that it would be open to a jury to find a person guilty of a particular offence'. I accept Counsel Assisting's submission that 'may have been committed' is a concept substantially lower than the ultimate criminal burden of proof beyond reasonable doubt.

61. Judge Cain also stated that the decision to make a notification under section 49(1) is substantially different to the one required to be made by the Director of Public Prosecutions. The Director is guided by an extensive and comprehensive policy that requires a prosecution may only proceed if there is both a reasonable prospect of a conviction and the prosecution is in the public interest.¹¹ In determining whether there is a reasonable prospect of conviction, the policy identifies ten separate factors that the Director is required to have regard to. Those are considerations for the Director of Public Prosecutions. They are not considerations for the Coroner.

¹⁰ COR 2020 3809, 1 December 2022. Available [here](#). See in particular paras 333-340.

¹¹ See: <https://www.opp.vic.gov.au/wp-content/uploads/2023/09/DPP-Policy-21-September-2023.pdf>

62. I agree with and adopt the observations of then-State Coroner Judge Cain above with respect to the appropriate operation of section 49(1) of the Act.
63. I have given careful consideration to whether there is a basis for me to make a notification under section 49(1) of the Act in relation to the conduct of the driver in this case. I am of the view that, given the low threshold for such notification – namely, that an indictable offence *may* have been committed in connection with the death – there is indeed such basis and that I am obliged to request the Principal Registrar make such notification.
64. In drawing this conclusion, I note that: (i) while Victoria Police conducted a detailed review of the circumstances of Bailey’s passing and assessing whether the driver ought to be charged in relation to the collision (via Sgt Howie, who is an experienced police member and well-placed to make such assessments as a former MCIU detective, and who made a comprehensive statement in this matter), there is fresh evidence available since the time he made such assessment, in particular, the Supplementary Collision Reconstruction Report of D/Sgt Hardiman, which includes relevant opinion as to speed, risk and survivability that was not previously in the possession of the Coronial Investigator; (ii) while I have considered carefully the submissions made on behalf of the driver, it is not for me to consider as Coroner whether an indictable offence is capable of being made out, merely whether one ‘*may have been committed*’, which was unfortunately not addressed in the driver’s submissions; and (iii) in circumstances where I consider that the speed of the driver was a contributing factor to the collision, the result of which was the death of a cyclist, there is a sufficient basis to give rise to a belief an indictable offence *may* have been committed.
65. In this connection, I have not given detailed consideration to whether the elements of any particular indictable offence appear to be made out on the evidence at the criminal standard of standard proof, being ‘*beyond reasonable doubt*’. That is not part of the coronial function. In investigating Bailey’s passing, as Coroner, my role is not to weigh the evidence to determine whether the degree of contribution of the driver is sufficient to have any indictable charge made out, and I am in fact explicitly disallowed from making any finding that a person is guilty of an offence, ‘or *may be*’, pursuant to section 69 of the Act. Parliament intended for such evidentiary assessments, as they relate to criminal matters, to come within the purview of the DPP and/or Victoria Police alone.

66. I note for completeness that the driver was not charged with any discrete speeding offence related to the collision. This has caused considerable distress to Bailey's family. However, noting that this would be summary in nature (and now in any event time-barred), I do not consider it would give rise to a section 49(1) notification.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Bailey Peer Harry, born 19 April 1996;
- b) his passing occurred on 6 May 2021 at Alfred Health, The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from multiple injuries sustained in a bicycle incident (rider); and
- c) his passing occurred in the circumstances described above.

COMMENT

I make the following comment to **Monash City Council** on a matter connected with Bailey's passing, pursuant to section 67(3) of the Act:

1. The local area in which this collision occurred has been identified by a Monash City Council study as one in which physical traffic management interventions would be beneficial. While recognising that all such measures will be the subject of prioritisation according to need in light of available resources, I urge **Monash City Council** to continue to gauge the need for such measures (and/or reduced speed limits in the area) as recommended in the Study it commissioned and received the findings of in 2024. The community's reported concerns about speeding in the area are borne out in this case, and a greater awareness about the potential impacts of exceeding the posted speed limit even in what might be considered to be the 'lower end' speed zones should be a matter of public education, reflection and action as appropriate.

ACKNOWLEDGEMENTS

I convey my sincere condolences to Bailey's family for their profound loss. I consider that the conclusion that Bailey's own conduct contributed to the collision and outcome does not in any way diminish the fact that his passing is a tragedy that has reverberated through his family and broader Community. Nor in this case does it detract from the role of the Coroner to look

at prevention opportunities, such as those related to the intersection and any improved safety measures.

Bailey's family have noted in correspondence to me that *'Bailey was a young man with a huge heart. He was a loving father to his three children. He was the heart and jewel of the family, and the glue that held everyone together. Bailey's death was tragic and has left a huge void in the family. He is irreplaceable and is deeply missed by his family'*. It is clear that his untimely passing is felt keenly by all who loved and cared for him.

ORDERS AND DIRECTIONS

I order that a copy of the present finding be published on the Coroners Court website in accordance with the Rules.

I direct that the Principal Registrar notify the Director of Public Prosecutions of the present finding in accordance with section 49(1) of the Act.

I direct for a copy of this finding to be provided to:

Taylah-Leigh Burns, Senior Next of Kin, via the Victorian Aboriginal Legal Service (VALS)

The driver

Senior Constable Stuart Deitz, Victoria Police, Coronial Investigator

Monash City Council

Department of Transport and Planning

Signature:



Ingrid Giles

CORONER

Date: 25 November 2025



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.
