



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2021 005158**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner David Ryan
Deceased:	Jon Gorr
Date of birth:	3 June 1959
Date of death:	28 September 2021
Cause of death:	1(a) Head, chest and pelvic injuries, sustained in a cycle versus car motor vehicle incident
Place of death:	Tooram Road, Allansford, Victoria, 3277

## INTRODUCTION

1. On 28 September 2021, Jon Gorr was 62 years old when he died from injuries sustained when he was struck by a car while cycling. At the time of his death, Mr Gorr lived in Allansford with his wife, Marion Gorr.
2. Mr Gorr is fondly remembered as a sociable man and passionate teacher who was devoted to his Jewish faith.

## BACKGROUND

3. In her statement to police, Ms Gorr described her husband as a “*keen cyclist*” who was “*safety aware*” and “*a competent steady rider*”. Mr Gorr cycled between 15 to 25 kilometres each day and was rarely deterred by inclement weather. Although Mr Gorr was apparently not a fast rider, Ms Gorr recalled that he “*would be steady in his pace*” and “*would ride in a straight line*”. According to Ms Gorr, her husband always wore a helmet and carried a bag with “*hi-vis*” markings while cycling, and had lights affixed to the front and rear of his helmet that he activated even during daylight hours. She was aware that he often carried his phone and earbuds with him, but does not believe he listened to music or answered phone calls while cycling.<sup>1</sup>
4. Conversely, Victoria Police received several witness accounts, by way of formal statements and reports to Crimestoppers, which describe Mr Gorr’s manner of cycling as unsteady and dangerous. Witnesses variously recalled that Mr Gorr often drifted on bicycle paths to their outmost edge and when on the highway, he “*sort of goes all over the road*” and did not ride in a straight line. One witness in particular recalled a recent incident in which Mr Gorr failed to give way to a driver who had to swerve and take evasive action to avoid colliding with him.<sup>2</sup>

## THE CORONIAL INVESTIGATION

5. Mr Gorr’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.

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<sup>1</sup> Statement of Marion Gorr dated 28 October 2021.

<sup>2</sup> Statement of Keira Gordon dated 1 November 2021; Statement of Ernest Fary dated 26 November 2021; Coronial brief, Summary of Information Reports received via Crimestoppers.

6. 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.
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 comments or recommendations in appropriate cases about any matter connected to the death under investigation.
8. Victoria Police assigned an officer to be the Coroner’s Investigator for the investigation of Mr Gorr’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.
9. This finding draws on the totality of the coronial investigation into the death of Mr Gorr including evidence contained in the coronial brief. While 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.<sup>3</sup>

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

### **Circumstances in which the death occurred**

10. On 28 September 2021, Mr and Ms Gorr spent the morning together working on a building project. At approximately 1.00pm, they drove to a supermarket in Warrnambool East, where Ms Gorr went shopping and Mr Gorr readied his bicycle to ride home. In her statement to police, Ms Gorr advised that she had offered to drive her husband to Hopkins Point Road, however he declined and advised that he would take the Princes Highway “*as it is safer as there is a hard shoulder*”.<sup>4</sup>

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<sup>3</sup> 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.

<sup>4</sup> Statement of Marion Gorr dated 28 October 2021.

11. Ms Gorr subsequently passed her husband on her drive home. She then visited a friend who lived on the corner of Garabaldi Lane and Ziegler Parade. As they shared a cup of tea, Ms Gorr observed her husband on his bike turning right onto Ziegler Parade from Garabaldi Lane. Ms Gorr suspected that he would cycle past Hopkins River to look at the ducks and then continue onto Tooram Road to return home.<sup>5</sup>
12. At approximately 2.40pm, Keira Gordon was mowing the lawn outside her home on the corner of Maria and Agnes Streets, Allansford, when she observed Mr Gorr cycling along Agnes Street before turning onto Maria Street towards Tooram Road. Ms Gordon recalled that Mr Gorr was wearing a helmet and a fluorescent orange backpack, and noticed that he appeared to be “*struggling he was puffing, out of breath*”.<sup>6</sup>
13. A short time later, William Bennett was driving in a northerly direction along Tooram Road. In his statement to the Court, Mr Bennett recalled that there were no other cars on the road in front of him. The relevant section of Tooram Road is divided into two lanes of traffic for north and southbound travel and has a sign posted speed limit of 60 kilometres per hour. As Mr Bennett passed the intersection with Maria Street—at which road users were directed by a sign to give way prior to entering into Tooram Road—Mr Bennett heard a “*large thud*” and observed a “*black blur*” to the left of his car in his peripheral vision.<sup>7</sup>
14. At this time, Ernest Fary was in the living room of his home on Tooram Road when he heard “*a loud metallic sound*”. Mr Fary went outside to investigate and observed a damaged bicycle on the road between three to four metres north of the intersection of Maria Street and Tooram Road. He then observed Mr Gorr lying on Tooram Road beside a bus shelter and Mr Bennett’s car between eight to ten metres away.<sup>8</sup>
15. Mr Bennett moved his car to the edge of the road before joining Mr Fary and an off-duty nurse in rendering assistance to Mr Gorr. The nurse tried to stem the bleeding from Mr Gorr’s head injury and Mr Fary held up a towel to shield him from the sun. Mr Fary recalled that Mr Gorr was breathing at this time and he observed his helmet on the nearby nature strip.<sup>9</sup>

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<sup>5</sup> Statement of Marion Gorr dated 28 October 2021.

<sup>6</sup> Statement of Keira Gordon dated 1 November 2021.

<sup>7</sup> Statement of William Bennett dated 22 February 2022.

<sup>8</sup> Statement of Ernest Fary dated 26 November 2021.

<sup>9</sup> Statement of Ernest Fary dated 26 November 2021.

16. Ambulance Victoria paramedics arrived at approximately 2.53pm and observed that Mr Gorr had sustained multiple injuries, including a severe head wound, which were noted to be “*possibly consistent*” with having gone underneath the vehicle post-impact. He was recorded as having a Glasgow Coma Scale (**GCS**)<sup>10</sup> score of 3 and laboured breathing.<sup>11</sup> Mr Gorr was intubated and responding paramedics administered oxygen therapy and assisted ventilations, applied a pelvic splint, and tried to stabilise him for transport to hospital by helicopter. Due to a delay in the arrival of the helicopter, paramedics decided to transfer him by road to Warrnambool Base Hospital and cancelled their request for an Air Ambulance.<sup>12</sup>
17. While being loaded into the ambulance a short time later, Mr Gorr went into cardiac arrest and paramedics commenced cardiopulmonary resuscitation (**CPR**) and applied a defibrillator. Despite exhaustive resuscitation efforts, Mr Gorr remained unresponsive and paramedics considered his injuries were too extensive to continue CPR. He was subsequently pronounced deceased at 3.30pm.<sup>13</sup>

### **Identity of the deceased**

18. On 28 September 2021, Marion Gorr visually identified the deceased as her husband, Jon Gorr, born 3 June 1959.
19. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

20. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 29 September 2021 and provided a written report of his findings dated 30 September 2021.
21. Dr de Boer reviewed a post-mortem computed tomography (**CT**) scan, which revealed multiple traumatic fractures to the ribs, pelvis and lumbar vertebra, subarachnoid and

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<sup>10</sup> The Glasgow Coma Scale (GCS) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.

<sup>11</sup> Ambulance Victoria, Electronic patient care record completed by MICA Single Responder dated 28 September 2021.

<sup>12</sup> Ambulance Victoria, Electronic patient care record completed by two-person Warrnambool paramedic crew dated 28 September 2021; Ambulance Victoria, Electronic patient care record completed by Rotary Wing Aircraft crew dated 28 September 2019.

<sup>13</sup> Statement of Shane Hammond dated 22 December 2021; Ambulance Victoria, Electronic patient care record completed by two-person Warrnambool paramedic crew dated 28 September 2021.

subperitoneal haemorrhages, and bilateral pneumothoraces. Dr de Boer also observed external bruises and abrasions, predominantly to the left-hand side of the body.

22. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.
23. Dr de Boer provided an opinion that the medical cause of death was 1(a) Head, chest and pelvic injuries, sustained in a cycle versus car motor vehicle incident.
24. I accept Dr de Boer's opinion.

## **FURTHER INVESTIGATION**

25. Mr Bennett underwent a preliminary breath test and oral fluid test by Victoria Police at the scene, which were negative for alcohol and illicit drugs. He later provided a blood sample for toxicological analysis, the results of which were similarly negative for alcohol and illicit drugs.<sup>14</sup>
26. Police examined the surrounding area and determined that the point of impact was approximately 10.1 metres north of the centre line on Maria Street. Mr Gorr's bicycle was approximately 9.1 metres north of this point and he had been thrown a further six metres north. The absence of tyre marks on the road surface at the point of impact suggested that Mr Bennett did not observe Mr Gorr immediately prior to impact in order to brake or take evasive action.<sup>15</sup>
27. Detective Sergeant Dr Jenelle Hardiman (**D/Sgt Hardiman**) of the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) of Victoria Police conducted a collision reconstruction, assisted by a Traffic Incident System Report, scene diagram and photographs. Having observed the damage sustained by Mr Gorr's bicycle and Mr Bennett's car, D/Sgt Hardiman formed the opinion that Mr Gorr's bicycle was impacted from the rear by the front passenger side of Mr Bennett's car. She was unable to determine whether Mr Gorr was travelling along Tooram Road at the time of the collision, or whether he had turned onto Tooram Road from Maria Street. D/Sgt Hardiman estimated that at the time Mr Bennett struck Mr Gorr, he was travelling between approximately 48 to 50 kilometres per hour.<sup>16</sup>

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<sup>14</sup> Statement of Leading Senior Constable Mark Kirby dated 2 December 2021.

<sup>15</sup> Statement of Leading Senior Constable Mark Kirby dated 2 December 2021.

<sup>16</sup> Statement of Detective Sergeant Dr Jenelle Hardiman dated 31 October 2021.

28. Forensic Officer Dale Woodland of the CRMIU conducted a mechanical investigation of Mr Bennett's car, during which he observed minor impact damage to the front passenger side. The examination did not reveal any faults or failures associated with Mr Bennett's car that would have caused or contributed to the collision.<sup>17</sup>
29. Police examined Mr Bennett's mobile phone and identified that he last received a text message immediately prior to the incident at approximately 2.44pm. They were unable to determine whether or not Mr Bennett read the text message upon receipt, but there was no evidence to suggest he responded to the message or made any calls immediately prior to the collision.<sup>18</sup> Police also obtained an extract of Mr Bennett's driving offences, which revealed that his most recent offence occurred in June 2020 and his driver licence was suspended between 12 July 2020 and 12 October 2020 for exceeding the speed limit.<sup>19</sup>
30. Police ultimately did not charge Mr Bennett with any offence in connection with Mr Gorr's death.

## **FINDINGS AND CONCLUSION**

31. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Jon Gorr, born 3 June 1959;
  - b) the death occurred on 28 September 2021 at Tooram Road, Allansford, Victoria, 3277, from head, chest and pelvic injuries, sustained in a cycle versus car motor vehicle incident; and
  - c) the death occurred in the circumstances described above.
32. Having regard to the observations of Ambulance Victoria paramedics as to the headphones located on Mr Gorr's person, it appears that he may have been distracted immediately prior to the collision. While the investigation has not revealed the precise circumstances that gave rise to the collision, having considered all of the available evidence, I am satisfied that it is likely that Mr Gorr failed to adequately give way at the intersection at Maria Street before turning into Tooram Road into the path of Mr Bennett's vehicle.

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<sup>17</sup> Statement of Dale Woodland dated 31 October 2021.

<sup>18</sup> Statement of Leading Senior Constable Mark Kirby dated 2 December 2021.

<sup>19</sup> Coronial brief, Extract of Road Safety Act offences for William Bennett.

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

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

Marion Gorr, Senior Next of Kin

Senior Constable Mark Kirby, Coroner's Investigator

Signature:



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Coroner David Ryan

Date : 25 May 2022

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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.

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