IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006040

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Brian Neil Smith
Date of birth:	6 April 1989
Date of death:	11 November 2021
Cause of death:	1(a) Multiple injuries sustained in a motorbike incident.
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050

INTRODUCTION

1. On 11 November 2021, Brian Neil Smith (**Brian**) was 32 years old when he died at the Royal Melbourne Hospital (**RMH**) as a result of injuries sustained in a motorcycle collision. At the time of his death, Brian lived at unit 2 of 15 Marlo Drive, Melton West, Victoria.

2. Brian had been riding motorcycles for approximately 10 years and held a valid licence and registration at the time of his passing.[1] A certificate under Section 84(1) of the *Road Safety Act 1986* disclosed that Brian's motorcycle licence had been suspended on two occasions, in 2011 and 2012, for excessive speed, and that he had not incurred any traffic infringement notices since June of 2017.

3. Brian's family described him as someone who had a good heart, and was always generous with his time and money. They spoke of his love for his two nephews and his passion for computers.[2]

THE CORONIAL INVESTIGATION

4. Brian'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brian's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

[1] Coronial brief, statement of Lesley Smith dated 17 May 2022, page 11; VicRoads Driver's Licence extract dated 27 September 2022.
[2] Coronial brief, statement of Lesley Smith dated 17 May 2022, page 11.

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Brian Neil Smith 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]

9. In considering the issues associated with this finding, I have been mindful of Brian's basic 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

10. On 17 November 2021, Brian Neil Smith, born 6 April 1989, was visually identified by his mother, Lesley Smith.

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

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

12. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 12 November 2021 and provided a written report of her findings dated 19 November 2021.

13. The post-mortem examination revealed multiple and significant traumatic injuries consistent with the history given.

14. Toxicological analysis of post-mortem samples identified the presence of ondansetron, ketamine, and lignocaine.[4] Alcohol was not detected.

[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.

[4] The presence of these medications may likely be attributed to medical interventions undertaken following the collision.

15. Dr Parsons provided an opinion that the medical cause of death was from 1(a) multiple injuries sustained in a motorbike incident.

16. I accept Dr Parson's opinion.

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

17. On 11 November 2021 at approximately 8:25am, a prime mover truck driven by Regan Prendergast was travelling along the Western Freeway near the Deer Park Bypass towards the city when he began to merge from the left-hand lane into the right-hand lane. Mr Prendergast stated that he was travelling at approximately 45km/hr due to the heavy traffic and was indicating as he merged.[5]

18. As Mr Prendergast completed the lane change, he looked into his rear-view mirror and observed a 'commotion' behind him, with cars pulling over onto the median strip. Mr Prendergast stopped his truck and was informed by a witness that a motorbike had collided with the rear of his vehicle, however Mr Prendergast was unaware that the incident had occurred.[6]

19. Witness Christopher Hearne, who was driving a van 'maybe two cars' back from the collision, stated that he observed a red motorcycle splitting lanes and travelling faster than the surrounding traffic, at approximately 60km/h. Mr Hearne observed Mr Prendergast's truck merge into the right-hand lane with its indicators operating, then describes seeing the motorcycle 'taking a dive'. [7] To Mr Hearne, the motorcyclist appeared to be attempting to overtake the truck as it merged and, despite braking heavily, collided with the rear of the truck, resulting in the rider being thrown on to the embankment.[8]

20. In his statement, Mr Prendergast describes looking in his mirrors after completing the lane change and seeing a 'commotion' behind him and cars pulling onto the median strip. Mr Prendergast states he pulled over, 'scared that something had happened', and that he was unaware the motorcycle had collided with him until he was told by a witness who had also stopped.[9]

[5] Coronial brief, statement of Regan Prendergast dated 17 November 2021, page 14; statement of First Constable Duanne Cottom dated 6 April 2022, page 21.
[6] Coronial brief, statement of Regan Prendergast dated 17 November 2021, page 14.
[7] Coronial brief, statement of Christopher Hearne dated 17 November 2021, page 16.
[8] Coronial brief, statement of Christopher Hearne dated 17 November 2021, page 16.
[9] Coronial brief, statement of Regan Prendergast dated 17 November 2021, page 12.

21. The scene where the collision occurred was on the Western Freeway, close to the Robinsons Road exit. It is a four-lane sealed roadway travelling in an east-west direction. There are two lanes for traffic travelling in each direction, separated by a grass embankment with a wire barrier. There is a broken white line separating each lane, with a fog line and sealed shoulder. On the day of the collision, the weather was fair, the road dry, and there was good visibility.[10]

22. Emergency services attended the scene at 8:27am and found the motorcycle rider, Brian, lying on the embankment between the inbound and outbound lanes with severe injuries. Brian was quickly transported to the RMH Emergency Department (**ED**), arriving at 9:40am.[11]

23. On arrival at the RMH ED, Brian's condition rapidly deteriorated and, despite intensive resuscitation efforts, he passed away at 10:35am.[12]

POLICE INVESTIGATIONS

24. Following the collision, Mr Prendergast was cleared from the scene as it appeared to attending police that Brian's injuries were not serious. Upon being notified that Brian's injuries were life-threatening, police recalled Mr Prendergast and required him to undergo drug and alcohol testing.[13] A blood sample taken on 11 November 2021 at 10:28am was analysed and no ethanol (alcohol), methylamphetamine, delta-9-tetrahydrocannabinol or 3, 4-Methylenedioxymethamphetamine (MDMA) was detected.[14]

25. Police photographed the collision scene and captured the damaged rear wheel guard of Mr Prendergast's truck, which is distorted at an angle that suggest it was struck from behind, at a point between the central number plate and the inside edge of the rear driver's side wheel.[15]

26. Police spoke to witnesses at the scene and noted:

[10] Coronial brief, Exhibit 1, photographs.
[11] Coronial brief, statement of First Constable Duanne Cottom dated 6 April 2022, page 21; Dr Yusi Liu, Medical E-Deposition dated 11 November 2021.
[12] E-Medical Deposition dated 11 November 2021, Dr Yusi Liu, Royal Melbourne Hospital.
[13] Coronial brief, statement of First Constable Jack Slipper dated 28 February 2022, p.23; statement of Senior Constable Jordyn Briggs dated 23 February 2022, p.27.
[14] Coronial brief, VIFM toxicology certificate of approved analyst, dated 6 December 2021, p.106.
[15] Coronial brief, photo exhibits, p.70-72.

a) 'From all witness accounts, it appeared that the motorcycle had collided with the rear of the truck after trying to 'overtake' it as the truck was merging into the right lane';[16] and

b) 'a male […] observed the truck merging into the right-hand lane of the freeway, and he could see the bike travelling into the right-hand lane afterwards', though this witness did not see the collision itself.[17]

27. No criminal charges were laid in connection with the collision.

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.[18] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made 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 Brian Neil Smith, born 06 April 1989;

b) the death occurred on 11 November 2021 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050, from *multiple injuries sustained in a motorbike incident*.; and

c) the death occurred in the circumstances described above.

[16] Coronial brief, statement of First Constable Jack Slipper dated 28 February 2022, p.22.
[17] Coronial brief, statement of Senior Constable Jordyn Briggs dated 23 February 2022, p.26.
[18] *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…'.

30. Having considered all the available evidence:

a) I am satisfied that Brian was riding in an unsafe manner given the speed of the traffic and that his attempt to overtake the truck whilst it was merging was a significant and contributing factor in the collision that subsequently claimed his life; and

b) Though Mr Prendergast does not expressly describe checking his rear-view mirrors before merging, I am not satisfied, on the balance of probabilities, that he was driving in an unsafe manner when he merged into the right-hand lane. I am also unable to be satisfied to the requisite standard that, had he done so, he would have observed Brian in sufficient time to avoid the collision, given the apparent point at which the motorcycle impacted with the prime mover, and the motorcycle's sudden manoeuvring described by witnesses shortly before the collision.

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

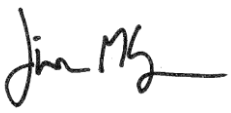
I direct that a copy of this finding be provided to the following:

Lesley Smith, Senior Next of Kin

Kellie Gumm, Royal Melbourne Hospital

Senior Constable Jordyn Briggs, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 04 December 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.