IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001937

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Bria Kathleen Joyce
Date of birth:	04 October 1996
Date of death:	08 April 2022
Cause of death:	1(a) Injuries sustained in a motor vehicle collision
Place of death:	Kulkyne Way, Iraak, Victoria, 3496

INTRODUCTION

1. On 08 April 2022, Bria Kathleen Joyce was 25 years old when she passed away in a motor vehicle accident whilst on duty at the rank of Senior Constable as a member of Victoria Police. At the time of her passing Bria lived in Red Cliffs.

2. Bria was the only daughter to her mother Diana and is survived by her partner, Kyle. She was born in Port Macquarie, New South Wales before moving to Manilla, New South Wales when she was six weeks old. Her first jobs were at the local IGA supermarket and bowling club, completing a traineeship in logistics before joining Victoria Police on 22 August 2016.

3. Upon graduating from the Police Academy, she was initially stationed at Moonee Ponds prior to transferring to Mildura Uniform where she spent most of her time. In October 2021 Bria transferred from Uniform into the Mildura Highway Patrol where she was serving at the time of her passing.

4. In addition to her police service, Bria was extremely fit and healthy, competing in triathlons, participating in musical orchestras and during the recent bushfires sewed pouches to assist injured kangaroos.

THE CORONIAL INVESTIGATION

5. Bria'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.

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 Bria'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 Bria Kathleen Joyce 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]

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

Circumstances in which the death occurred

Joshua Moore

10. On the afternoon of Friday 8 April 2022, Joshua David Moore attended the Irymple Pub after travelling back from Mildura whilst catching up with his parents and sister who described him as being '*in good spirits throughout the pub*' and '*was all smiles and all happy. He was glad to have finished work for the week*'. He returned to his parents' house, had a shower and then left about 6.30pm, telling his parents he was going to see a mate to drop some headers off and then go around and catchup with another mate. As he departed his father said to him '*be safe and make sure you ring me in the morning*' with Joshua responding, '*yeah Dad, yeah, yeah*'.

11. Approximately 7.11pm Joshua attended the Nangiloc Tavern and met up with a mate whom he had texted earlier in the afternoon and who described Joshua as being in good spirits and '*we spoke about general shit together, specifically what was happening at work with the crew. We also talked about some cylinder heads he had refurbished for a ski boat*'. Towards the end of the evening, he asked Joshua what his plans were for later that evening who indicated he might camp out in Lamberts Island.

[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.

12. During the evening Joshua spoke with another friend who was there who described that '*he was a little bit quieter than normal which I just put down to me being with my family. Normally we get fucked up on the beers and get a bit loud*'. The bartender who knew Joshua well described him as '*quieter than normal. He seemed a little flat. He is normally more smiley and cheerful. He didn't say that anything was up, but I didn't ask either*'.

13. Between 7.11pm and 9.09pm Joshua purchased and consumed two pots of Carlton dry at 7.13pm and 7.28pm and three schooners of Carlton dry at 7.52pm, 8.21pm and 8.44pm. He left the Nangiloc Tavern at 9.09pm driving alone in his blue 2009 Nissan Navara utility and initially headed south on Kulkyne Way.

14. The whereabouts of Joshua are unknown between 9.09pm and 9.54pm however within the collision scene, Joshua's mobile phone was located and later analysed. A video file recovered from this mobile phone was a video recorded at 9.50pm of three seconds duration showing Joshua drinking a Carlton Dry beer whilst driving.

<u>Senior Constable Bria Joyce</u>

15. Senior Constable Bria Joyce and Leading Senior Constable Thomas Kinnane commenced duty at 6.00pm at Mildura Highway Patrol. That shift Senior Constable Joyce was the driver whilst Leading Senior Constable Kinnane was the observer, within an unmarked white 2021 BMW X5 Highway Patrol vehicle, callsign Mildura 610.

16. At 9.07pm Senior Constable Joyce received a telephone call from a good friend of hers, informing that the friend's partner and father had been drinking excessively and then decided to go and check a fish net which they had placed in the Murray River in Red Cliffs. The friend informed Senior Constable Joyce that the partner had a history of drink driving with a zero condition on his licence. Senior Constable Joyce indicated to her friend that it was a quiet night, and that she was only patrolling at the moment, so would drive over in that direction and see if she was able to locate them.

Motor Vehicle Collision

17. At 9.54pm on Friday 8 April 2022, Senior Constable Bria Joyce was driving south in the south bound lane of Kulkyne Way, between Danes Road and Forbes Road in an unmarked Victoria Police Highway Patrol vehicle, a white BMW X5, callsign Mildura 610. At the same time Joshua Moore was driving in the opposite direction along Kulkyne Way in a blue Nissan Navara utility. At that time Joshua's vehicle has crossed to the incorrect side of the road and travelled into the south bound lane and collided head-on with Senior Constable Joyce's vehicle before both vehicles separated post-impact.

18. Travelling behind the BMW was a white Toyota Camry being driven by Gurjant Singh that had secondary impacts with both the BMW and Nissan as the force of the impact between the BMW and Nissan caused them to rotate and separate. Neither Gurjant Singh, Jagjeet Singh who was the front passenger or three children in the rear of the vehicle were seriously injured in the collision.

19. An occupant within the vehicle driven by Gurjant Singh immediately contacted triple zero. Numerous vehicles driving on Kulkyne Way also came across the collision scene and immediately stopped and rendered assistance as did an owner from a nearby property who had heard the collision and drove out to investigate. The BMW vehicle also made an automated call to emergency services after it detected the collision.

20. In response to multiple triple zero calls received, the Emergency Services Telecommunications Authority (ESTA) broadcast a job for a persons trapped accident with serious injuries at the location with Victoria Police, Ambulance Victoria, Country Fire Authority and State Emergency Service expediting to the location.

21. Senior Constable Joyce regrettably passed away upon impact prior to the arrival of emergency services. Leading Senior Constable Kinnane was extracted from the front passenger seat of the BMW, seriously injured and transported to Mildura Base hospital by ambulance paramedics. As a result of the collision, he suffered serious injuries including a traumatic brain injury, spinal injuries, upper and lower limb injuries, chest and abdominal injuries. He had no memory of the actual collision.

22. Joshua was extracted from the driver's side of the Nissan seriously injured with treatment being rendered by ambulance paramedics however passed away shortly thereafter.

23. The Major Collision Investigation Unit (MCIU) from Melbourne were activated and travelled to the location to conduct a forensic examination of the collision scene.

24. Detective Senior Constable Zhao examined the collision scene and made the following observations and opinions:

Kulkyne Way

a. Kulkyne Way in the collision area was a two-way two-lane bitumen road that ran essentially north-south. The opposing lanes were separated by a solid white painted line for southbound traffic and a broken white painted line for north bound traffic. Both lanes were bordered by solid white painted fog lines, beyond which were short bitumen shoulders leading to wide gravel shoulders and rural farmland. There was no provision of street lighting in the area.

b. Kulkyne Way in the collision area was essentially straight. There was a slightly elevated crest approximately 200 metres south of the collision area, however no obstruction to sighting was identified. The road was in good condition with no apparent faults or defects that would have contributed to the collision.

BMW X5

c. The BMW was at rest facing east on the gravel shoulder of the southbound lane. It sustained extensive frontal impact offset towards the driver side, resulting in deep crush to the front and complete loss of vehicle's front driver side corner including the front driver wheel and the radiator. The crush on the driver side reached the firewall which was also pushed rearward.

d. The bonnet of the BWM was folded from the middle and hanging to the front passenger side. This indicated an impact in the direction of driver side to passenger side. Sporadic blue paint transfer was visible throughout the surface of the bonnet, which had a lateral impression of a bar connecting both edges. The driver side front bumper of the BMW with corresponding cavities for headlight and fog light was located at the scene. It displayed an imprint of a half number plate next to the border to the grille that matched the last three numbers/letters of the Nissan. There was no apparent contact damage to the rear section of the BMW.

e. The interior of the BMW was completely destroyed at front panels, which was pushed into the cabin and became fragmented. Both seatbelts at the front were extended and locked with stretch marks, suggesting they were worn at the time of the collision. Airbags were deployed.

Nissan Navara

f. The Nissan was at rest facing northeast on the fog line of the northbound lane. It sustained major front-to-rear impact offset to the driver side causing the front to crush and the cabin to bow towards the passenger side. The cabin was severely deformed with a collapsed roof on the driver side and a dislodged driver door. The bonnet was folded up in the middle and had multiple paint loss and scrape marks towards the leading edge. The front passenger wheel was dislodged from its axle and resting with its inner side wall facing up.

g. The Nissan was fitted with a bull bar that maintained its lateral structure and was similar in appearance to the bar-shaped imprint on the bonnet of the BMW. It had lateral scrape marks with white paint transfer towards the driver side. The dashboard of the Nissan was pushed into the cabin depriving most of the space of the driver side. The driver's seatbelt was retracted and locked, suggesting it was not worn at the time of the collision. Airbags were deployed.

Collision Scene

h. Both the BMW and the Nissan displayed severe frontal crush slightly offset towards the driver side resulting from a head-on collision. The collision occurred well in the southbound lane of Kulkyne Way. The overlapping area between the BMW and the Nissan at impact was approximately 1.47 metres, which was 75% of full head-on impact on the BMW and consistent with previous assessment that the impact was slightly offset towards the driver side of both vehicles.

Airbag Control Module/Bosch Crash Data Retrieval | BMW X5

i. The five seconds of pre-crash data contained speed, acceleration, braking and steering information that can be used to determine the movement of the BMW. It showed that the BMW was cruising at a steady speed of 96km/h (92-99km/h with error range) until 2 seconds before the collision when the brake was activated. Speed dropped gradually from 96km/h to 83km/h at impact in the next two seconds, suggesting the brake input was only minor with an average deceleration of 1.8m/s^2. No activation of the antilock-braking system (ABS) was recorded. There was no steering input throughout the recording period to indicate the driver initiated any evasive action.

Speed | Nissan Navara

j. The Nissan Navara did not have an airbag control module capable of being downloaded and analysed by the Bosch Crash Data Retrieval software.

k. Utilising equations derived from the laws of momentum conservation, at impact, the Nissan was travelling between 101-152km/h.

Airbag Control Module/Bosch Crash Data Retrieval | Toyota Camry

l. The pre-crash data revealed that the Toyota was travelling at 97km/h (93-100km/h) at 4.55 seconds before the collision. It slowed down slightly from release of accelerator pedal over the next 3 seconds to 91km/h. The vehicle then braked hard for the ABS to be activated approximately 0.05 seconds before the collision with the rotating BMW. The impact speed of the Toyota was 71-76 km/h and there was no meaningful pre-impact steering input.

Conclusion

m. The BMW X5 was travelling south in the southbound lane of Kulkyne Way when it collided head-on with the Nissan Navara, which was travelling north with the majority of its body in the southbound lane. The BMW and the Nissan separated post-impact, and both travelled southbound. The Toyota Camry was travelling behind the BMW and passed between the BMW and the Nissan and was impacted by both vehicles before coming to stop under emergency braking.

n. The BMW was travelling at approximately 92-99km/h before colliding with the Nissan at approximately 79-87km/h. The impact speed for the Nissan was approximately 101-152km/h. The Toyota Camry was travelling at 93-100km/h before colliding with the BMW at approximately 71-76km/h.

25. Investigations undertaken at a later date determined that:

a. the vehicle registrations on both the BMW X5 and the Nissan Navara were current.

b. Senior Constable Joyce held a current full unrestricted driver's licence with no recorded traffic infringements. She also held a Victoria Police Full Silver Approved Driving Authority.

c. Joshua Moore held a current full unrestricted driver's licence with three (3) current demerit points. He had three prior infringements recorded against his driver's licence for drive without P plates (January 2017), exceed speed by less than 10km/h (May 2018) and exceed speed by 10-14km/h (October 2020).

Identity of the deceased

26. On 9 April 2022, Bria Kathleen Joyce, born 04 October 1996, was visually identified by Victoria Police member and colleague, Detective Sergeant Stephanie McKay.

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

Medical cause of death

28. Forensic Pathologist, Dr Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 11 April 2022 and provided a written report of her findings dated 13 April 2022.

29. The external examination and CT scan revealed widespread fractures and internal injuries, consistent with a high-speed front-on collision, and were fatal.

30. Toxicological analysis of post-mortem samples identified only the presence of a low concentration of paracetamol. No ethanol or any other substances were detected.

31. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION.

32. I accept Dr Glengarry's opinion.

ASCERTAINING THE CAUSE OF THE MOTOR VEHICLE COLLISION

JOSHUA MOORE'S VEHICLE CROSSING TO THE INCORRECT SIDE OF ROADWAY

33. I find, on the basis of the following evidence, that the Nissan Navara ute being driven by Joshua Moore was being driven north along Kulkyne Way, when it has crossed to the incorrect side of the roadway into the southbound lane and impacted head-on with the BMW being driven by Senior Constable Bria Joyce, causing the subsequent fatal collision:

    a. The Victoria Police BMW X5 was fitted with an In Car Video (ICV) system. The ICV automatically back captures 30 seconds and is triggered by activating the emergency lights and/or sirens or by being manually activated with a button within the cabin. For reasons unknown the ICV was activated at the time of the collision, it is unknown whether an electrical fault caused this or alternatively whether an item within the vehicle struck the manual activation button during the collision. It is clear from the footage that the BMW *did not* have its emergency lights or sirens activated in the 30 seconds before or at the point of impact. It does however clearly capture at all times pre-collision, the BMW travelled and remained fully within the southbound lanes on Kulkyne Way.

    b. The conclusion of Detective Senior Constable Zhao, Collision Reconstructionist who opined '*the BMW X5 was travelling south in the southbound lane of Kulkyne Way when it collided head-on with the Nissan Navara, which was travelling north with the majority of its body in the southbound lane. The BMW and the Nissan separated post-impact, and both travelled southbound. The Toyota Camry was travelling behind the BMW and passed between the BMW and the Nissan and was impacted by both vehicles before coming to stop under emergency braking*'.

    c. The evidence of Gurjant Singh, who was travelling directly behind the BMW being driven by Senior Constable Joyce, and who states '*we were following the white car, when all of sudden there was headlights coming from the other direction. The white car and we were going towards Nangiloc Way and the headlights, which I saw after the collision was a blue Nissan Navara ute, was coming from Nangiloc on Kulkyne Way. I first saw the ute when it was just about to hit the white car. The white car was just going straight as I was following it and all of a sudden, I remember the headlights coming towards the white car and hitting it. The blue ute hit the white car on the lane that we were both travelling in'*.

ROAD AND WEATHER CONDITIONS AND FAMILIARITY

34. Unfamiliarity with the road *cannot* be attributed as a causal factor in the fatal collision. His parents within their statement give evidence that '*Josh knew every stone on that road … … He travelled that road every week. He knew every part of it. Ever since he got his licence he has been travelling that road and even as a kid we drove that road. He knew it like the back of his hand*'.

35. At the time of the collision, various witnesses report that the road surface was dry, visibility was good and that there was no street lighting at the collision scene. Further I note the evidence of Detective Senior Constable Zhao that '*Kulkyne Way in the collision area was essentially straight. There was a slightly elevated crest approximately 200 metres south of the collision area, however no obstruction to sighting was identified … … the road was in good condition with no apparent faults or defects that would have contributed to the collision*'.

36. I find that the road and weather conditions at the time of the collision were *not* causal factors. Further I note that Joshua Moore had extensive experience driving along this stretch of roadway and therefore was extremely familiar with the location at the time.

MECHANICAL FAULT

37. On Monday 11 April 2022 Senior Constable Gardner, Mechanical Investigator with the Collision Reconstruction and Mechanical Investigation Unit (CRMIU) of Victoria Police Forensic Services Centre (VPFSC) conducted a mechanical examination of the 2008 Nissan Navara ute and made the following observations:

    a. The vehicle was fitted with an inertia reel lap sash type seat belt assembly to the D/S/F seating position. The seat belt reel was mounted in the lower section of the rear door which was severely impacted and distorted. The seat belt pretensioner had deployed and the belt was found to be locked in the retracted position. This is consistent with the seat belt not being used at the time of impact.
    b. All tyres showed no signs of malfunction, or failure, prior to the collision.
    c. The braking system, as inspected, showed no signs of malfunction, or failure, prior to the collision.
    d. The suspension systems, as inspected, showed no signs of malfunction, or failure prior to the collision.
    e. The steering system/s as inspected, showed no signs of malfunction, or failure, prior to the collision.

38. Senior Constable Gardner opined that '*my examination of the Nissan Utility did not reveal any mechanical fault or failures with this vehicle which would have caused, or contributed to, the collision. My examination revealed the headlights of the Nissan Utility were on high beam at the time of the collision*'.

39. I find that there is *no* evidence of any mechanical fault with the vehicle being driven by Joshua Moore that could have contributed to or been causal to the collision.

MEDICAL EPISODE | JOSHUA MOORE

40. Joshua's parents within their statement stated that '*Josh was recently complaining about chest pain. He would say that his chest would hurt and we'd say go to the doctor. His response 'narh she'll be right'. This had been going on for the last six months or so on or off. We were unaware whether he ever went to the doctor. We asked his ex-girlfriend to take him and she said he was old enough to make up his own mind*'.

41. I note the autopsy findings of Dr Archer, Forensic Pathologist, Victorian Institute of Forensic Medicine who determined following the post-mortem examination of Joshua's body, that '*there was no evidence of any natural disease that could have contributed to the death. Nor was there any evidence at autopsy of a medical event having precipitated the incident*'.

42. I find that there is no evidence to support a finding that Joshua suffered a medical episode immediately prior to the fatal motor vehicle collision.

FATIGUE

43. It is difficult to make an accurate assessment in respect of whether fatigue was contributory to the fatal collision. Whilst I note that Joshua was a fly-in fly-out worker for a mining company in Pooncarie, requiring him to work 12-hour shifts, I also note an analysis of his mobile phone call charge records indicates minimal call activity on his mobile phone in the 24 hours preceding the collision. This may be indicative, but in no way conclusive, of ample rest the night prior to the collision. I further note that that evening, the distance travelled by Josh between his home address and Nangiloc Tavern was by no means excessive, being approximately 35 kilometres.

44. I have also viewed the video captured on his mobile phone approximately four minutes prior to the fatal collision. Whilst I appreciate it is only three seconds duration, there is no evidence of fatigue shown within the video. Much more significantly it captures him recording himself on his mobile phone, whilst drinking a beer, moments before crossing to the incorrect side of the roadway.

45. I find that there is no evidence to support a finding that fatigue could have contributed to or been causal to the collision.

SUICIDE/INTENTIONAL SELF-HARM | JOSHUA MOORE

46. Joshua had been in a relationship for the past eight (8) years with AB (a pseudonym), whom he met at Red Cliffs High School. AB described their relationship as '*chaotic at times*'. AB ended their relationship in January 2022 and following the breakup, evidence on the brief establishes that Joshua struggled to cope initially with the end of the relationship and made several threats of self-harm and suicide. As his parents stated '*the relationship breakup broke his heart … … we talked him through it and stayed up with him one night to work through stuff, would have a lull, and then by the end of that phone call there would be a plan to do something else that he would focus on. By the next day he was good again*'. At the time of his passing however there appeared to be the prospect of a new relationship commencing causing Joshua, according to his parents, to '*get really happy again. We don't know who it was. It was very hush hush. We passed her in the car driving down the driveway once and that was it*'.

47. Following the fatal motor vehicle collision AB opined that '*I don't think Josh committed suicide, I think it's careless driving. Josh was one of the worst drivers I've ever seen. He's been in a lot of car accidents. He's always driving and using snapchat, he drinks and drives and doesn't stay in his lane … … He would always speed and sometimes (mainly when he was around the river and bushland) wouldn't wear his seatbelt*'.

48. A review of the Victoria Police LEAP system indicates there are *no* recorded mental disorder transfers in respect of Joshua, also referred to as apprehensions pursuant to s 351 *Mental Health Act*. Joshua's Medicare and PBS records were obtained as part of the coronial investigation that indicate for the 12 months prior to his passing, he had no GP consultations in respect of mental health, and no prescribed pharmaceutical items.

49. During the afternoon of Friday 8 April 2022 whilst Joshua was catching up with his parents at the Irymple Pub, they described him as being '*in good spirits*'. His sister described him at the pub as being '*all smiles and all happy. He was glad to have finished work for the week*'. I also note that as Joshua was leaving his parents house, they state that '*as he was walking out to the car he was chatting to a friend and asked her what she was doing tomorrow. He told her to give him a call and he'll come out with her tomorrow*'.

50. Further his mate who was drinking with Joshua at the Nangiloc Tavern that evening recalls that '*he seemed actually pretty good that night. I remember thinking he's finally making a turn when it came to AB and the whole situation*'. Another mate recalled conversing with Joshua during the evening and making plans for the following Sunday for him to attend Joshua's premises and fix a lawn mower.

51. I have thoroughly considered all of the evidence available on the coronial brief in respect of Joshua's personal circumstances and relationship history. Evaluating all of the above, I find that there is **insufficient evidence** to support a finding that the motor vehicle collision was an intentional act of self-harm/suicide by Joshua.

<u>DRIVER ERROR</u>

52. Firstly I note the objective evidence in respect of Joshua Moore's driving that evening:

    a. Post-mortem toxicology returned a blood alcohol level of 0.15-0.16 g/100ml; and

    b. Four minutes prior to the fatal collision, he recorded a three second video on his mobile phone, whilst driving, of him drinking a Carlton Dry beer; and

    c. He was not wearing a seatbelt at the time of the collision.

53. Secondly there is no evidence to suggest that there were any other vehicles in close proximity to the Nissan that would have caused or contributed to the collision. Similarly, there was no evidence to suggest that there were items or objects on the roadway to cause Joshua to take evasive action.

54. Thirdly the evidence is unsettled in respect of Joshua's driving history:

    a. His parents within their statement give evidence '*he wasn't a dickhead with the way he drove*'; however

b. His ex-partner of eight years, AB states that

i. '*While I was in Darwin, Josh crashed my Toyota Prado. That was my first serious car and he crashed it. It made me angry but not as angry as Josh when I'd bring it up. So I was forced to use his blue ute and he'd use his Brumby*';

ii. '*I don't think Josh committed suicide, I think it's careless driving. Josh was one of the worst drivers I've ever seen. He's been in a lot of car accidents. He's always driving and using snapchat, he drinks and drives and doesn't stay in his lane*';

iii. '*The blue ute, and other cars were poorly kept, it had a crack in the windscreen which was from when he punched it about 6 weeks ago. He would always speed and sometimes (mainly when he was around the river and bushland) wouldn't wear his seatbelt. One time he almost died when he was on his phone and missed a highway (including the stop sign) and drove straight into an embankment. He's rear ended someone in my Prado when I was away when he was driving through McDonalds drive through when he was drunk. The time he crashed my Prado he had been drinking too*'.

c. At the time of his passing he held a current full unrestricted driver's licence with three (3) current demerit points. He had three prior infringements recorded against his driver's licence for drive without P plates (January 2017), exceed speed by less than 10km/h (May 2018) and exceed speed by 10-14km/h (October 2020).

55. I find a combination of factors, being:

a. Joshua's blood alcohol concentration (high range 0.15-0.16g/100ml); and

b. Joshua's use of a mobile phone minutes prior to the fatal collision recording him driving whilst drinking a Carlton Dry beer;

to be primary contributory factors to Joshua's vehicle crossing to the incorrect side of the roadway and impacting head-on with the vehicle being driven by Senior Constable Joyce.

FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was Bria Kathleen Joyce, born 04 October 1996;

    b. the death occurred on 08 April 2022 at Kulkyne Way, Iraak, Victoria, 3496, from INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION; and

    c. the death occurred in the circumstances described above.

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

58. I also convey my sincere condolences to all of Bria's Victoria Police colleagues, in particular those who were required to attend the scene of the fatal collision that evening. I recognise the attendance of Superintendent John O'Connor, Inspector David Rowe, A/Senior Sergeant Liam Tinkler, Sergeant Penny Benson, Sergeant Joshua Smith, First Constable Levi Slinger, Constable Sean Hawking, First Constable Indiana Phillips, First Constable Ella Brown, Leading Senior Constable Ross Huxtable, Senior Constable Toby McMillan, Constable Jason Saulge, First Constable Tomas Gillahan, First Constable James Neville, Constable Georgia Tink and all other emergency services workers from Victoria Police, Ambulance Victoria, the Country Fire Authority and the State Emergency Service. I also recognise the courage of Detective Sergeant Stephanie McKay who was required to identify her colleague, and the permanent legacy this collision will have upon Leading Senior Constable Kinnane and his family.

59. Pursuant to section 73(1A) of the Act, and in accordance with the rules, I order that this finding be published on the Coroners Court of Victoria website.

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

    a. Kyle McCarthy, Senior Next of Kin

    b. Dianne Joyce, Bria's Mother

    c. Shane Patton APM, Chief Commissioner of Police

    d. Professional Standards Command, Victoria Police

    e. Senior Constable Jeremy Nelson, MCIU, Coroner's Investigator

Signature:

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CORONER JOHN OLLE

Date: 6 March 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.