IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 002657

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Yukako Fukuhara
Date of birth:	26 December 1974
Date of death:	17 May 2022
Cause of death:	1(a) Multiple head, chest and pelvic injuries sustained in a cycling incident
Place of death:	At the corner of King Street and La Trobe Street, Melbourne, 3000, Victoria
Keywords:	Cycling incident, cyclist death, heavy vehicle, multiple injuries

INTRODUCTION

1. On 17 May 2022, Yukako Fukuhara was 47 years old when she died in Melbourne's Central Business District (**CBD**) following a cycling incident. At the time of her death, she resided in North Melbourne. Ms Fukuhara is survived by her partner of six years, Nozomi Kobayashi, her adult daughter, Akira Fukuhara, and her mother, Takako Ishiwaki.

2. Ms Fukuhara was born in Japan and was described by her partner as an outgoing and happy person. Her hobbies and interest were varied, and she enjoyed travelling, music, art and riding her motorcycle.

3. Ms Fukuhara was described by her mother as having a love for the English language and always hoped to study it abroad. During March 2022, Ms Fukuhara moved to Melbourne on a tourist visa to pursue her English language studies.

THE CORONIAL INVESTIGATION

4. Ms Fukuhara'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 Ms Fukuhara's death. The Coroner's Investigator, Senior Constable Patrick Guinan, conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, 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 Ms Fukuhara 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]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. On 17 May 2022 at 5.12pm, Ms Fukuhara was riding her pink bicycle in a southerly direction on King Street in Melbourne's CBD. She was in the left lane, riding adjacent to Flagstaff Gardens. The weather was fine with good visibility.

10. At the same time, truck driver Satbir Singh was driving a white Scania P440 Tipper truck in the centre lane on King Street, also travelling in a southerly direction. The truck was towing a grey dog tipper trailer. The truck measured approximately 17 metres in length, with the trailer approximately 5.6 metres in length. The gap separating the truck from the trailer was 4.2 metres in length.

11. Due to peak hour conditions, traffic on the southbound lanes of King Street was backed up and extended past the La Trobe Street intersection. Several cars were stationary in the left-hand lane. Ms Fukuhara was observed on her bicycle between the stationary left-hand lane and the centre lane, which had some traffic flow. As the left lane ended in a left turn only, Mr Singh observed several cars attempting to merge from the left lane to the centre lane.

12. A Mercedes Benz driven by Cara Piazzata was stationary in the left lane, waiting to merge into the centre lane. Mr Singh observed the indicator light on the Mercedes Benz in his left side mirror. As Ms Piazzata had not yet started to merge, Mr Singh continued to slowly move his truck forward. He stated, 'it would have been too dangerous to stop the truck and brake to let her in, because I didn't want any cars behind to hit me.'

13. At this time, due to the stationary vehicles in the left lane, Ms Fukuhara also attempted to merge to the centre lane. Mr Singh stated that he was unable to see her from his position at this time. Ms Fukuhara moved into the 4.2 metre gap between the truck and the trailer. As Mr Singh was unaware of her presence, his vehicle moved slowly forward, and the front of the trailer clipped the rear wheel of Ms Fukuhara's bicycle. She lost her balance and fell off her

[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.

bike, into the path of the trailer. The rear left dual axles of the trailer then rolled over her, causing significant injuries.

14. Mr Singh felt a bump to the trailer and looked in his rear-view mirrors to see what had occurred. He stopped his vehicle and along with several other drivers, attempted to render assistance to Ms Fukuhara. She was motionless but still breathing and had significant facial injuries. Her helmet was cracked and loose. Cardiopulmonary resuscitation was commenced, and emergency services were contacted.

15. Police and paramedics arrived on scene shortly thereafter, but Ms Fukuhara was declared deceased. Mr Singh undertook a breath test examination which was negative for any alcohol or any other drugs. Police were provided with dashcam footage from several vehicles which revealed the circumstances of the incident.

IDENTITY OF THE DECEASED

16. On 24 May 2022, Yukako Fukuhara, born 26 December 1974, was identified DNA comparison at the Victorian Institute of Forensic Medicine (**VIFM**).

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

MEDICAL CAUSE OF DEATH

18. Forensic Pathologist Dr Heinrich Bouwer from the VIFM conducted an external examination on 19 May 2022 and provided a written report of his findings dated 2 June 2022.

19. The post-mortem examination revealed catastrophic head, chest and internal organ and pelvic injuries. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

20. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) Multiple head, chest and pelvic injuries sustained in a cycling incident.

21. I accept Dr Bouwer’s opinion

Correspondence from Ms Kobayashi

22. The Court received a heartfelt letter from Ms Kobayashi on 17 December 2022. She stated that she had reviewed the dashboard camera footage in this matter and indicated that the truck and dog trailer vehicle involved in this incident, are not seen on Japanese roads. Ms Kobayashi

raised the possibility that Ms Fukuhara may not have realised that the trailer was part of the tipper truck when she merged lanes. She stated that Ms Fukuhara was otherwise an experienced driver, motorcycle rider and cyclist who was cautious and aware of her surroundings. Ms Kobayashi stated, 'if Yukako had recognized those vehicles as a connected truck and trailer, it is highly unlikely that she would take the risk of riding between them.'

23. Ms Kobayashi outlined several suggestions which she hoped may improve road safety and prevent similar incidents of this nature in future. These included:

    a) New measures to prevent people, bicycles etc from entering the gap between trucks and dog trailers e.g.: installation of elasticated bands.

    b) Monitoring or warning system so if a person or bicycle enters the gap between the truck and dog trailer, the driver is immediately aware. Alarms or lights could also warn the person entering the area between the truck and dog trailer.

    c) Restrictions of vehicles of this type in busy urban areas such as the CBD.

    d) Improving awareness of the dangers of these vehicles to other road users.

24. I thank Ms Kobayashi for her thoughtful letter and the suggestions raised therein. I have considered possible preventative measures and propose a recommendation below.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Yukako Fukuhara, born 26 December 1974;

    b) the death occurred on 17 May 2022 at the corner of King St and La Trobe St Melbourne, 3000 Victoria, from 1(a) multiple head, chest, and pelvic injuries in a cycling incident: and

    c) the death occurred in the circumstances described above.

26. Having considered all of the evidence, I find that Ms Fukuhara's death was the result of an accident. On the day of the incident, traffic flow was heavy, and Ms Fukuhara was attempting to merge lanes on her bicycle to bypass stationary vehicles in the left lane. Ms Fukuhara had recently moved to Melbourne and despite being an experienced motorcycle rider and cyclist

in Japan, she may have been unaware that the truck and trailer driven by Mr Singh was in fact one vehicle, when she moved into the gap between them.

27. I convey my sincere condolences to Ms Fukuhara's family for their loss.

COMMENTS

28. Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

29. In Melbourne, cycling is a very common mode of transport and the number of cyclists on our roads continues to increase. However, cyclists are also amongst our most vulnerable road users and have little protection compared to most other road users. Consequently, they are exposed to a greater risk of death or injury when an incident occurs. Over the last five years, 55 bicycle riders have been killed on Victorian roads.[2] This is an average of 11 riders per year with the majority (56%) killed on metro roads.[3]

30. The Transport Accident Commission (**TAC**) is a Victorian Government-owned organisation whose role is to promote road safety and support those who have been injured. The TAC consistently runs major campaigns[4] to educate road users on various road safety issues such as driver fatigue, speed, and distraction from mobile phone use amongst others. Given the increasing number of cyclists on our roads, it may be appropriate for an awareness campaign to be developed, regarding the dangers of bike riding around trucks (trailer trucks).

RECOMMENDATIONS

31. Pursuant to section 72(2) of the Act, I make the following recommendation:

To Paul Younis, Secretary of the Department of Transport and Planning:

> In conjunction with the Transport Accident Commission (**TAC**), consider developing a public awareness campaign to highlight the dangers of cycling around trucks (trailer trucks) in an urban setting).

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[2] Transport Accident Commission Bicycle Rider Statistics, accessed at https://www.tac.vic.gov.au/road-safety/statistics/summaries/bicycle-rider-statistics#:~:text=96%20bicycle%20riders%20have%20been,average%20of%20nine%20each%20year

[3] Ibid.

[4] Transport Accident Commission Campaigns, accessed at https://www.tac.vic.gov.au/road-safety/tac-campaigns

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

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

    Nozomi Kobayashi, Senior Next of Kin

    Senior Constable Patrick Guinan, Coroner's Investigator

    Transport Accident Commission Victoria

    Department of Transport and Planning Victoria

Signature:

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Jacqui Hawkins, Deputy State Coroner

Date : 20 July 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.