IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005658

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Leslie Wallace Taylor
Date of birth:	27 January 1961
Date of death:	1 October 2022
Cause of death:	1(a) HEAD INJURY SUSTAINED ON IMPACT BY A CAR
Place of death:	Ballarat Road, Sunshine, Victoria, 3020

INTRODUCTION

1. On 1 October 2022, Leslie Wallace Taylor was 61 years old when he died after being struck by a motor car. At the time of his death, Mr Taylor lived at 99 Hertford Road, Sunshine, Victoria with his sister, Carol Taylor, who was his full-time carer.

THE CORONIAL INVESTIGATION

2. Mr Taylor'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.

3. 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.

4. 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.

5. Senior Constable (SC) Rachel Hutton acted as the Coroner's Investigator for the investigation of Mr Taylor's death. S/C Hutton conducted inquiries on my behalf and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Mr Taylor 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]

[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.

BACKGROUND

7. Mr Taylor was born in Sunshine and lived there all his life. He had six siblings and lived with his younger sister, Carol Taylor, who was his carer. Mr Taylor had an intellectual disability and was unable to communicate verbally, apart from being able to say a limited range of words. His medical history included hypertension, gout, and Type 2 diabetes mellitus.

8. Mr Taylor was known to venture out of his home without supervision and did this regularly into his adult years. Mr Taylor's family installed various measures at their home to prevent him from wandering, including a lock on the gate. However, these measures were not always successful. In January 2021, Ms Taylor gave her brother a tracker so that she could locate him if he ventured out without telling her.

9. Ms Taylor described Mr Taylor as a very sociable person. He was well known in the area, had a network of friends, and attended a day placement program during the week.

10. Mr Taylor's routine and social life were impacted by the COVID-19 restrictions and Ms Taylor noted that he began wandering from home more during this time, and afterwards.

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

Circumstances in which the death occurred

11. At approximately 2.00pm on Saturday 1 October 2022, Ms Taylor left home to assist her son, who having difficulties with his car. She advised her brother where she was going and checked the gate was locked when she left. When she returned home at approximately 4.00pm, Mr Taylor was absent.

12. At 8.24pm, Mr Taylor was walking next to the Ballarat Service Road, Sunshine North, approximately 150 metres east of the intersection between Ballarat Service Road and Anderson Road.

13. Diana Nagel was sitting in her vehicle on Ballarat Road when she saw Mr Taylor step onto the Ballarat Service Road, in the leftmost westbound lane. Ms Nagel stated that it appeared as though Mr Taylor was attempting to pick something up from the road surface.

14. After stepping onto the roadway, Mr Taylor was struck by a white 2003 Holden Commodore sedan driven by Joanne Blacker in the left lane. Also in the vehicle were three child passengers. Joanne Blacker stated:

I can't tell you if I was braking yet or not, but I know I wasn't accelerating because I was going up to the red light [at the intersection of Ballarat Rd Service Rd and Anderson Rd] *I went to put the radio on and as I put my head down for half a second and I saw something out the corner of my eye, I saw something grey. I didn't even get to put the radio on it happened that quickly.*[2]

15. Ms Taylor stated that her brother had a piece of heavy-duty rope that he took everywhere with him, as a security blanket of sorts, and loved collecting rope. A long length of white twine (or small diameter rope) was found on the road at the scene. The bulk of the material was coiled on the road surface near the point of impact and the remainder lay in a path to Mr Taylor's body. The impact damage to the Holden Commodore sedan was principally over the left half of the bonnet and left windscreen. I conclude that Mr Taylor was attempting to retrieve the coil of twine from the left lane of the roadway when he was struck.

16. Ms Blacker immediately stopped her vehicle – approximately 15 metres from the from the point of impact. She approached Mr Taylor and asked one of the children to call emergency services.

17. Ms Nagel, having witnessed the collision, also rushed to help Mr Taylor and began cardiopulmonary resuscitation.

18. Victoria Police members and Ambulance Victoria paramedics arrived shortly afterwards and took over attempts to resuscitate Mr Taylor. However, despite their best efforts, he could not be saved and was confirmed deceased at the scene.

Identity of the deceased

19. On 4 October 2022, Leslie Wallace Taylor, born 27 January 1961, was visually identified by his brother, Colin Taylor.

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

Medical cause of death

21. Forensic Pathologist, Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 3 October 2022 and provided a written report of her findings dated 7 October 2022.

[2] Statement of Joanne Blacker dated 1 October 2022 at p.2

22. The post-mortem examination and CT scan revealed injuries including a large right parietal scalp haematoma, a complex and slightly depressed right temporoparietal skull fracture with diastasis of the coronal suture around the left zygoma. There was a right zygoma fracture, small left parietal subarachnoid haemorrhage. Rib fractures to the left 4th lateral and right 6th – 8th posterolateral ribs were noted.

23. Toxicological analysis of post-mortem samples identified the presence of pholcodine and prazosin.

24. Dr Baber provided an opinion that the medical cause of death was 1 (a) head injury sustained on impact by a car.

25. I accept Dr Baber's opinion.

VICTORIA POLICE INVESTIGATION

Scene Examination

26. Victoria Police investigators examined the scene and noted that Ballarat Road, to the east of Harvester Road, is a six-lane carriage way with three eastbound lanes and three westbound lanes. The east and westbound lanes are divided by a grassed medium strip. Ballarat Road is subject to a speed limit of 70 km/h.

27. Approximately 80 metres east of the intersection of Ballarat Road and Harvester Road this configuration changes. The left (southernmost) westbound lane has painted white arrows on its surface which indicate that drivers can either turn left into Harvester Road or continue straight across the intersection before veering left into the newly formed Ballarat Service Road where this lane widens into two marked lanes. The centre lane and right (northernmost) lane of Ballarat Road continues westward.

28. Ballarat Road and Ballarat Service Road are separated initially by a painted traffic island and then a grass and tree lined median strip. The road surface is sealed and in good condition and the speed limit remains at 70 km/h.

29. Ballarat Service Road, between Harvester Road and Anderson Road, has four power poles, three on the southern side and one on the centre median strip. Of the three on the southern side, only one has a streetlamp fitted. S/C Hutton noted that the streetlamps in this area emit an orange light which is of poor quality, especially during inclement weather. I take this to be an observation concerning sodium vapour streetlamps which provide poor colour rendering,

more glare, less even illumination, and less overall efficiency when compared with modern LED streetlamps.

30. At the time of the collision, the roads were dry, and the weather was fine. The street lighting was operational and traffic was light. All traffic control signals applicable to pedestrians and motor vehicles were operating in normal sequence and were clear to view. There were no parked vehicles or other obstructions on Ballarat Road Service Road at the time of the collision.

31. The coroner's investigator suggested that the implementation of better street lighting along this section of road would increase visibility and may potentially prevent further collisions occurring. I agree that the adequacy of the street lighting in the relevant area is questionable and should be reviewed by the responsible authorities. There is however some complexity in this regard as I understand Ballarat Road falls within the control of Head, Transport for Victoria while Ballarat Road Service Road falls within the auspices of Brimbank City Council – hence my recommendation is directed to both authorities.

Criminal investigation

32. As a result of these events Ms Blacker was initially charged with careless driving[3], however this charge was later withdrawn. There was no evidence of excess speed, driver impairment or vehicle defect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Leslie Wallace Taylor, born 27 January 1961;

    b) the death occurred on 1 October 2022 at Ballarat Road, Sunshine, Victoria, 3020, from head injury sustained on impact by a car; and

    c) the death occurred in the circumstances described above.

[3] Careless Driving is an offence contrary to s.65 of the *Road Safety Act* 1987 and carries a maximum penalty of 12 penalty units for a first offence.

RECOMMENDATION

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

> That Brimbank City Council and Head, Transport for Victoria review the adequacy of the street lighting along the Ballarat Road Service Road in the vicinity of the site of the collision to ensure safe levels of illumination for pedestrians, motorists and other road users.

COMMENTS AND DIRECTIONS

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

I thank the Coroner's Investigator and those police members assisting for their work in this investigation.

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

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

Colin Taylor, Senior Next of Kin

Senior Constable Rachel Hutton, Coroner's Investigator

Brimbank City Council

Head, Transport for Victoria

Signature:

Coroner Paul Lawrie

Date : 24 April 2024

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.