IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004721

FINDING INTO DEATH WITHOUT INQUEST[1]

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr ZLS
Date of birth:	[redacted]
Date of death:	24 August 2023
Cause of death:	1a: INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (DRIVER)
Place of death:	22 Kimpton Way Altona Victoria 3018

[1] Related to case **COR 2023 004722.**

INTRODUCTION

1. On 24 August 2023, Mr ZLS was 34 years old when he died in a motor vehicle collision on Kimpton Way in Altona. At the time of his death, Mr ZLS lived in Ravenhall, Victoria, with his partner.

2. Mr ZLS was born to parents, Ms AWH and Mr BWH, and was raised alongside his sister in the Altona Meadows area.

3. By all accounts, Mr ZLS had a passion for cars, beginning at a young age when he was gifted a quad bike. As he grew up, Mr ZLS was described as *'modifying and upgrading and customising anything with wheels'*, which he would sell for a profit. He owned several businesses, located in an industrial estate in Altona.

4. On 13 August 2023, nine days before his death, Mr ZLS purchased a 2017 Audi Quattro R8 Coupe (**the Audi**).

5. Mr ZLS had prior traffic offences including careless driving, speeding and driving with a suspended licence. At the time of his death, he was the subject of a police investigation for unrelated matters.

Medical History

6. For several years, Mr ZLS attended a general medical practitioner, Dr Kieran Keane (**Dr Keane**). Since his adolescence, Mr ZLS experienced anxiety and panic episodes. In 2010, he was prescribed an anti-depressant with good effect.

7. On 8 June 2023, Mr ZLS reported to Dr Keane he was experiencing increased anxiety, and was using benzodiazepines to self-medicate. His medication was not changed and according to Dr Keane, *'there was no indication he was suffering from depression'*, though he was experiencing traits of obsessive-compulsive disorder. This was Mr ZLS's final visit to the GP.

THE CORONIAL INVESTIGATION

8. Mr ZLS'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr ZLS's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Mr ZLS's death until it came under my purview in September 2023 for the purposes of obtaining additional materials, finalising the investigation and handing down this finding.

13. This finding draws on the totality of the coronial investigation into the death of Mr ZLS 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 24 August 2023, Mr ZLS was at work, at Project Performance on Kimpton Way. At approximately 6:15pm, he left and travelled to another of his businesses, on Rosie Place, in the same industrial estate. Mr ZLS had left his Audi at Rosie Place earlier in the day.

15. When Mr ZLS arrived at Rosie Place, he met Mr JZQ for the first time. Mr JZQ was a friend of Mr ZLS's business partner, Danny Wheeler, and was at Rosie Place having a motorcycle

[2] 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.

photographed. Mr JZQ reportedly asked Mr ZLS to take him for a ride in the Audi, to which Mr ZLS agreed, and the two men left the premises in the vehicle.

16. Individuals at the industrial estate recall hearing the Audi: *'I heard a car going down Kimpton Way at a high rate [of] speed, the engine was revving extremely high and it was very loud'.*

17. At 6:41pm, closed circuit television (**CCTV**) footage captured the Audi travelling east on Kimpton Way. The vehicle manoeuvred a right-hand bend and crossed into the opposite side of the road. Approximately half-way down Kimpton Way, the Audi veered suddenly to the right and impacted a tree on the nature strip. The collision was heard by nearby individuals who rushed to the scene and contacted emergency services.

18. The impact was so great that it caused the Audi to split into two, and the rear half of the vehicle landed 30 metres from the tree. Ambulance Victoria and Fire Rescue Victoria arrived at the scene and at approximately 7:08pm, they extricated Mr ZLS from the Audi. He was unconscious, not breathing and pulseless with multiple limb injuries. Mr ZLS was in asystole[3] and at 7:09pm, was declared deceased.

19. Mr JZQ was also declared deceased at the scene.

IDENTITY OF THE DECEASED

20. On 28 August 2023, Victoria Police used a fingerprint impression obtained from the deceased and identified it as belonging to Mr ZLS. On 29 August 2023, Dr Jan Jenkinson, Forensic Expert, of the Victorian Institute of Forensic Medicine (**VIFM**) completed an Identification Report to this effect.

21. State Coroner, Judge John Cain, reviewed the available evidence and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was Mr ZLS, born [redacted]. Accordingly, his Honour signed a Determination by Coroner of Identity of Deceased (**Form 8**), dated 29 August 2023.

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

[3] A form of cardiac arrest in which the heart stops beating.

MEDICAL CAUSE OF DEATH

23. Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) of the VIFM conducted an examination on the body of Mr ZLS on 28 August 2023. Dr Lynch considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 29 August 2023.

24. The post-mortem CT scan demonstrated craniocervical dislocation with intracranial haemorrhage and a right haemothorax.

25. Toxicological analysis of post-mortem samples identified the presence of fluoxetine[4] at a concentration of ~0.06 mg/L and trace amounts of paracetamol. There was no ethanol (alcohol) detected.

26. Dr Lynch provided an opinion that the medical cause of death was 1(a) *injuries sustained in motor vehicle collision (driver).*

27. I accept Dr Lynch's opinion.

VICTORIA POLICE INVESTIGATION

The Collision Scene

28. Members of the Westgate Highway Patrol attended the scene of the collision shortly after it occurred, and liaised with Victoria Police Major Collision and Investigation Unit (**MCIU**) as to how best to measure and maintain the integrity of the scene.

29. Kimpton Way is a single lane, two-way, sealed road within the industrial estate. There is no white line dividing the lanes, except at its intersection at Drake Boulevard. Kimpton Way is approximately 11.3 metres wide and is bordered by a gutter and nature strip. There is a speed limit of 50 km/h.

30. Kimpton Way and Drake Boulevard are known 'hoon' driving hot spots. According to coronial investigator, Senior Constable Matthew Meade, individuals perform high risk driving and are often seen 'drifting' around corners. There are no speed humps on Kimpton Way.

[4] An anti-depressant medication belonging to the class of selective serotonin reuptake inhibitors (SSRIs).

Mechanical Inspection

31. On 9 November 2023, Forensic Officer Dale Woodland (**FO Woodland**), of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**), conducted a mechanical inspection on the Audi.

32. FO Woodland noted there were burn marks to the webbing of the driver's seat belt, possibly indicating it was being worn at the time of the collision.

33. FO Woodland provided his conclusion as follows:

> *'My examination of the vehicle did not reveal any faults, failures or conditions that could have caused or contributed to the collision'.*

Collision Reconstruction

34. Detective Sergeant Robert Hay (**D/S Hay**), also of the CRMIU, completed a reconstruction of the collision. D/S Hay was provided with a scene sketch, several photographs, access to the Traffic Incident System and provided a copy of his opinion dated 20 September 2023.

35. On Kimpton Way, D/S Hay noted a single curved tyre mark which extended towards the impacted tree. Pieces of the Audi were spread along the nature strip, extending approximately 43 metres away from the point of impact.

36. From the damage to the tree and Audi, D/S Hay determined that the vehicle impacted the tree at the front passenger door, and it appeared to have been airborne at the time.

37. D/S Hay turned to consider the Audi's speed at the time of impact. He stated that, *'based on [his] experience, when a vehicle is ripped in half the impact speed is a minimum of 100 km/h'.*

38. D/S Hay provided his conclusion as follows:

> *'Based on the information and the calculations [. . .], the speed of the Audi sedan at impact with the tree was a minimum of 100 km/h, and between 108 km/h to 111 km/h at the start of the tyre mark. The true speed at the commencement of the tyre mark is likely to have been much higher but I am unable to reliably calculate that speed'.*

The Audi's Airbag Control Module

39. D/S Hay accessed the Audi's airbag control module (**ACM**). An ACM records data including from the vehicle's sensors, seatbelts, speed and other collision data.

40. The ACM report indicated four *'events'* and there were 3841 ignition cycles at the time of download. Recorded events 2 and 3 were captured at 3840 ignition cycles on 24 August 2023, at 6:48pm, according to the vehicle's internal clock.

41. However, there was no data attached to these records. D/S Hay stated this may have been due to a sudden loss of power due to the collision. As a result, there was no pre-collision data available from the system.

42. Audi did not respond to Victoria Police enquiries in relation to assistance in accessing and interpreting the ACM.

MODIFICATIONS MADE TO THE AUDI

43. During my investigation, it became apparent that several modifications had been made to the Audi. In 2020 and 2021, it appears that the Audi was modified to include turbocharges to the factory engine, a non-original intake manifold and alterations to the fuel system. Evidence indicates the modifications increased the Audi's power by approximately 1000-wheel horsepower (**WHP**).[5]

44. I sought a statement from the Department of Transport (**the Department**) regarding whether the Audi was compliant with the relevant requirements of the *Road Safety (Vehicles) Regulations 2021* (**the Regulations**) or other applicable laws at the time of Mr ZLS and Mr JZQ's deaths.

45. On 30 July 2024, a representative of the Department responded that there was no evidence that the Audi was compliant with the requirements of the Regulations. This was because the modifications to the vehicle had not been certified in accordance with regulation 35.[6] There was no evidence of a VASS Approval Certificate having been issued to the modified Audi as required by regulation 35(c)(ii).

[5] According to information published online by the modifications company that altered the Audi.

[6] According to regulation 35(c), for a light vehicle, (i) the modification must comply with relevant guidelines under regulation 9(1), (ii) an authorised vehicle inspector has issued a VASS approval certificate for the vehicle, or (iii) the modification is otherwise acceptable to the Secretary of the Department.

46. The representative further stated that the Audi was not registered in Victoria on 24 August 2023. It was instead registered in NSW at the time. There was no evidence of the Audi's modifications having been certified in another Australian State or Territory.

47. On the basis that the modifications to the Audi had not been certified and accepted for registration in any Australian State or Territory, and considering the modifications made, the representative stated he *'[does] not believe the vehicle would have been capable of being compliant'* with the Regulations at the time of the collision.

Absence of Reference to Modifications in the Mechanical Inspection and Reconstruction Reports

48. The modifications to the Audi were not detailed in the mechanical inspection report. I acknowledge there was extensive damage to the Audi, which may have rendered the identification of all modifications difficult.[7]

49. While Victoria Police is to be commended for its very thorough and detailed investigation, it remains that in circumstances where significant alterations have been made to vehicles, which may affect the power, safety and/or handling of a vehicle, they ought to be referenced and considered in Victoria Police inspection reports with the view to assisting coroners in their investigations and in making findings. While there may have been no evidence of faults or failures associated with the Audi that could have caused or contributed to the collision, its extensive modifications (rendering it to be in breach of applicable road regulations) were highly relevant to the circumstances of the collision and associated prevention opportunities.

50. I will distribute this finding to the CRMIU of Victoria Police for their consideration.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr ZLS, born [redacted];

    b) the death occurred on 24 August 2023 at 22 Kimpton Way Altona Victoria 3018, from 1(a) *injuries sustained in motor vehicle collision (driver)*; and

    c) the death occurred in the circumstances described above.

[7] I note for completeness, that some modifications were visible during the inspection. When provided with photographs captured during the mechanical inspection, the Department of Transport representative was able to identify the gold intake manifold.

52. Having considered all of the circumstances, I find that the fatal collision occurred when Mr ZLS was driving at excessive speed – at approximately double the posted speed limit, and likely higher – which caused him to lose control of his vehicle and impact with a tree with such force that the vehicle was torn into two pieces. The collision resulted in the deaths of both Mr ZLS and his passenger, Mr JZQ.

53. I note that Mr ZLS was prescribed anti-depressants and experienced mental ill health, and that he was under investigation by police for criminal offences at the time of his death. However, there is insufficient evidence to permit me to make a finding that Mr ZLS caused the collision intentionally. Rather, the collision occurred in the context of Mr ZLS '*showing off*' his vehicle to a new acquaintance, who was travelling as a passenger with him at the time of the collision was also, tragically, killed as a result.

54. I find that the collision occurred due to the combination of accelerating to excessive speed and Mr ZLS's relative inexperience in driving the very powerful vehicle that he had acquired merely days earlier.

55. I note that the vehicle had been significantly modified and that its wheel horsepower was increased, though the precise impact of these modifications on the vehicle's handling is unclear. I accept that the evidence demonstrating that modifications made to the vehicle meant it would not likely have been considered compliant with the *Road Safety (Vehicles) Regulations 2021* and that the vehicle could not be lawfully driven on Victorian roads.

COMMENTS

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

<u>Hooning in Victorian streets</u>

56. Mr ZLS's manner of driving, and the excessive speed at which he was driving the Audi at the time of the collision, gives rise to considerations of '*hoon driving'*. Indeed, earlier in August 2023, Mr ZLS's company had hosted a 'Show and Shine' event at his Kimpton Way factory. Many attendees were reportedly present for the event, with multiple '000' calls describing that a crowd had formed at the intersection of Drake Boulevard and Kororoit Creek Road and were reportedly enticing the drivers of vehicles, involved in the event, to engage in intentional high-risk driving. Later footage of Mr ZLS that was taken prior to the fatal collision and uploaded to the internet also depicts him engaging in high-speed driving in the Audi with an associate.

57. Hoon driving, or *'hooning'*, is generally defined in Australia as anti-social behaviour that includes street racing and speed trials, burn outs, donuts, drifting, unnecessary speed or acceleration.[8] In Victoria, hoon driving (in its various forms) is prohibited under various provisions in the *Road Safety Act 1986*, *Crimes Act 1958* and *Road Safety Rules 2009* and can give rise to a number of criminal offences.

58. As part of Victoria's Road Safety Strategy 2021-2023, which aims to implement new initiatives to reduce the prevalence of high-risk driving behaviours, the Victorian Department of Transport commissioned a report into hoon driving. The report, entitled, *'Identifying approaches to address the hoon behaviours of drivers in local communities and any newly identified motivations behind the behaviour'* (**the Report**) was released in September 2022 and identified that hoon driving causes *'a deterioration of the community's sense of safety and security'*.[9]

59. The Report stated that hoon drivers in Australia are predominantly young (<25 years) and male (75-100% of hoon driver samples). In Australia, drivers who have had their cars impounded for hooning offences are generally in their late teenage years, or early twenties – in Victoria, 83% of offenders were under 23 years old. While there is evidence to suggest that many young people *'mature'* out of the behaviour, there are many drivers who continue hoon driving into their adulthood.[10]

60. There is evidence to support that *'growing up with car modifying and street racing culture'* was also associated with street racing, as a specific form of hoon driving.[11]

61. It is unclear how many motor vehicle collisions and fatalities occur each year due to hoon driving. The Report anticipates that collisions are likely underreported because they may be minor, and the drivers are likely to be *'wary of the repercussions'* of reporting a crash, such as possible criminal charges. In Queensland, survey results indicated that 20% of respondents who reported hoon driving, reported being involved in a collision while hoon driving. Of those, 27% were willing to continue hoon driving.[12]

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[8] Watson-Brown et al, Centre for Accident Research & Road Safety Queensland, Final Report to the Department of Transport, Victorian State Government, *'Identifying approaches to address the hoon behaviours of drivers in local communities and any newly identified motivations behind the behaviour'* (**the Report**). Dated September 2022 and accessible at: Hooning_FinalReport-26092022.pdf.

[9] The Report, 'Executive Summary'.

[10] The Report, page 21-22.

[11] The Report, page 22.

[12] The Report, page 24.

62. In 2022, the Victorian Government formed the Hooning Community Reference Group following a reported increase in hoon driving. In the 12 months leading to 31 March 2023, dangerous driving offences in Victoria rose by 17%. Victoria Police attributed the increase to anti-hoon operations and active policing to target dangerous drivers.[13]

63. In several jurisdictions, hoon driving is punishable by vehicle impoundment.[14] Impoundment may be beneficial to prevent further hooning - a Victorian study demonstrated that 70% of hoon drivers who had their vehicle impounded (and who responded to the survey), reported no further engagement in the behaviour.[15]

64. According to the Report, infrastructural changes, such as speed humps, have received mixed commentary with *'some suggesting speed humps attract hoon drivers who experience the humps as a driving challenge to be conquered'*.[16]

65. Anti-hoon driving efforts require a coordinated effort and collaboration between councils, police and transport departments. An important aspect, as identified by the Report, is self-policing within motor enthusiast communities to foster a culture that is more critical of antisocial and potentially fatal behaviours.[17]

66. Rather than making recommendations to install traffic calming measures at places of known frequent hooning, such as Kimpton Way, or other recommendations regarding police operations targeting hooning drivers and/or or modified vehicles, I have elected to notify my findings to the Hooning Community Reference Group to assist in informing its future prevention-focused initiatives. It is my belief that this group is best-placed to determine what measures are required to reduce the risks associated with hoon driving and to increase driver and public safety.

67. I consider this to be of critical importance in the context of the present investigation, noting that the collision involving the Audi claimed not one, but two lives. Noting that there were other members of the public nearby along Kimpton Way at the time of the collision, the toll could easily have been higher.

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[13] *'Victoria records 17 per cent increase in dangerous driving offences in one year',* Ben Zachariah, Drive. Published 15 June 2023 and accessible at: Victoria records 17 per cent increase in dangerous driving offences in one year.
[14] For example, section 84E of the *Road Safety Act 1986* (Vic) enables Victoria Police to search, seize, impound or immobilise a vehicle if they reasonably believe it was used in a relevant offence.
[15] The Report, page 12.
[16] The Report, page 19.
[17] The Report, page 35.

I convey my sincere condolences to Mr ZLS's family for their profound loss. I acknowledge that Ms AWH, Mr ZLS's mother, has noted that Mr ZLS was much loved and was dedicated to helping his family and friends.

I also acknowledge the valiant efforts of first responders at a very difficult and traumatic collision scene, and to D/S Hay and SC Meade of Victoria Police for their ongoing and very valuable assistance with this investigation.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Coroners Court website in accordance with the Rules. I direct that a copy of this finding be provided to the following:

Ms HST, Senior Next of Kin

Ms AWH

The Collision Reconstruction and Mechanical Investigation Unit, Victoria Police

Hooning Community Reference Group

Transport Accident Commission

Department of Transport

Audi Australia

Senior Constable Matthew Meade, Coronial Investigator

Signature:

Ingrid Giles
Coroner
Date: 10 July 2025

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.