IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006737

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr TMP[1]
Date of birth:	[redacted] 1995
Date of death:	19 November 2024
Cause of death:	1a: Multiple injuries sustained in a motor vehicle incident (driver)
Place of death:	Western Highway Buangor Victoria 3375
Keywords:	Motor vehicle incident; Western Highway Upgrade; cultural heritage; Djab Wurrung Heritage Protection Embassy; Cultural Heritage Management Plan; Victoria's Big Build; driver fatigue; stress related to visa status

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased and other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication

INTRODUCTION

1. On 19 November 2024, Mr TMP was 29 years old when he died from injuries sustained in a motor vehicle incident, which occurred when the car he was driving crossed onto the incorrect side of the road and struck a truck head-on the Western Highway, Buangor.

2. Mr TMP grew up in Mish Mish, Lebanon. He travelled to Australia on 13 November 2023 with the intention of visiting family and staying for a three-month holiday, but subsequently decided to stay in Australia due to ongoing conflict in his region. While in Australia, Mr TMP lived with his sister, Ms MWR, in Hoppers Crossing, Melbourne. Mr TMP also visited his brother Mr NJQ, and his three children, who lived in Adelaide, on around three occasions, always travelling from Melbourne by plane.

3. Mr TMP's family stated that they were not aware of any significant medical history and that Mr TMP had no known mental health issues or any history of self-harm or suicidal ideation. However, there is some evidence which suggests that Mr TMP may have been experiencing a number of stressors in the period leading to his death. Mr TMP's best friend, Mr DKA, described that he was aware that Mr TMP had "*struggled*" when he first arrived in Australia due to challenges associated with his living circumstances and the language barrier. Mr DKA further noted that Mr TMP "*did seem a little depressed because he was having issues obtaining a visa*."

4. Mr TMP's Migration Agent also stated that Mr TMP had expressed "*unhappiness with his situation in Australia and mentioned having attempted to return to Lebanon on several occasions*." She stated that during their first meeting on 11 November 2024, Mr TMP had appeared "*emotionally distressed and overwhelmed*" in relation to his visa situation. Mr TMP subsequently attended her office again on the morning of his death, with no appointment, and appeared to be "*clearly unsettled*," as well as "*tired, anxious, and visibly unwell*." Further details of this second visit are discussed below.

5. There is also some evidence which suggests that Mr TMP may have been experiencing financial pressures. While Mr TMP had worked as a professional tiler in Lebanon, he did not have work rights in Australia but would complete "*odd job[s]*" for cash once or twice a week. Mr TMP's sister stated that she was aware that he had lent some money to friends in Australia and was having trouble getting this money back. Mr TMP's brother stated that there were times that Mr TMP would be given money from family members, and that he had been given a lot of money from family at the time that he first arrived in Australia. Mr TMP's Migration Agent also noted

that Mr TMP reported that a family member had paid for his visa to Australia and had repeatedly asked him for money.

6. In relation to Mr TMP's driving history, it was noted that Mr TMP held a Republic of Lebanon Driver Licence but had not obtained a Victorian Driver Licence. Mr TMP did not own a car in Victoria but borrowed his niece's Hyundai Santa Fe to get around *"once in a while*". Mr DKA described that Mr TMP had a history of speeding when driving, that he would "*usually speed*" when he drove, and that he once sought Mr DKA's advice in relation to paying speeding fines of approximately $1000. Mr TMP's brother stated that on each of Mr TMP's three previous visits to Adelaide, Mr TMP had always travelled by plane.

7. Mr DKA described that Mr TMP was "*humble, friendly, generous and an honest man.*" His sister, Ms MWR, also described that she had a close relationship with Mr TMP, and that he was "*very kind and supportive*" of her and her six children.

THE CORONIAL INVESTIGATION

8. Mr TMP'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, First Constable Larissa Gunn, to be the Coronial Investigator for the investigation of Mr TMP's death. The Coronial 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.

12. Following a review of the Coronial Brief, and taking into account all available evidence, I subsequently determined to refer this matter to the Coroner's Prevention Unit (**CPU**) to provide advice on whether there may be any prevention opportunities arising out of the circumstances in this matter.

13. This finding draws on the totality of the coronial investigation into the death of Mr TMP, including evidence contained in the coronial brief and advice provided by the CPU. 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]

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

Circumstances in which the death occurred

14. On 19 November 2024, at approximately 12.25pm, Mr TMP was involved in a two-vehicle fatal collision on the Western Highway in Buangor.

15. Two days prior, on 17 November 2024, Mr TMP had spoken to his brother Mr NJQ on the phone. Mr TMP stated that he was planning to attend his best friend's wedding on 19 November 2024, and that he would subsequently come to Adelaide to visit Mr NJQ and his children. Mr NJQ had assumed that Mr DKA would fly as he had always done on previous visits to Adelaide.

16. On the evening prior to Mr TMP's death, 18 November 2024, Mr TMP told his sister, Ms MWR, that he planned to stay at a hotel that night, as Ms MWR's two daughters were coming to stay and he considered that there was not enough room in the house. Ms MWR tried to convince Mr TMP to stay but he refused, indicating that he had already paid for the hotel and would be back in the morning, and giving her a hug and a kiss before leaving.[3]

17. That evening, Mr TMP was getting a haircut at Sayers Road Barbershop, when he ran into his best friend, Mr DKA, whose wedding was scheduled to be held the following day in Altona. Mr DKA described that Mr TMP appeared excited to attend his wedding and congratulated him. Mr TMP left the barbershop around 7.30-8pm. As he was leaving, Mr TMP offered to assist

[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.

[3] Victoria Police has been unable to confirm whether Mr TMP in fact booked and stayed in a hotel that night, and if so, any further details in regard to his movements in this regard.

Mr DKA if he needed any help prior to the event ceremony and asked whether it would be possible to bring another guest to the wedding. Mr TMP had already reserved seats for his sister and her two daughters and his nephew. Mr TMP did not tell Mr DKA where he was going.

18. The next morning, at approximately 8am on 19 November 2024, Mr TMP phoned Mr DKA who did not answer as he was busy preparing for his wedding.

19. At approximately 9am, Mr TMP phoned his brother, Mr NJQ, and stated that he was coming to Adelaide to visit. Mr NJQ reported that Mr TMP seemed happy and excited to see Mr NJQ's children.

20. Around 9am or 9.30am, Mr TMP had attended his Migration Agent without an appointment and asked to speak with her urgently. Mr TMP reportedly appeared "*tired, anxious and visibly unwell*" and "*[h]is demeanour was calm but clearly unsettled.*" Mr TMP told his Migration Agent that he had been driving all night and had been stopped by police but did not have identification on him. He stated that he had told police that he would return, but instead planned to leave the State and mentioned moving between Adelaide and Sydney. Mr TMP became upset and referred to a number of stressors related to his visa status and family relationships, stating, "*I've had enough*" and "*I'm tired of everything*." Mr TMP also told his Migration Agent he wanted to bring his mother and brother to Australia, so that he could "*rest*". She obtained details and began to prepare them a tourist visa application.

21. Mr TMP left the Migration Agent at approximately 10.30am. Upon leaving, she told Mr TMP to be careful and to get some rest before he drove.

22. At approximately 10.42am, Mr TMP phoned his sister, Ms MWR, and indicated that he was planning to go see a lawyer to help sort out arrangements for their mother to come to Australia, and then planned to drive to Adelaide to see his brother. Ms MWR reported that he seemed "*fine*" when she spoke with him.[4] Ms MWR suggested to him that he should fly, but Mr TMP responded that he "*didn't know how to book one and he will just drive instead*".

[4] Ms MWR stated that she spoke with Mr TMP at approximately 10.30-11am that morning. However, given that Mr TMP attended the Migration Agent and made enquiries in regard to visa arrangements for their mother at approximately 9-9.30am, I consider that it is possible that this phone call may in fact have occurred prior to this time, such that Mr TMP was referring to his intention to visit the Migration Agent. Otherwise, there is no evidence to indicate what lawyer Mr TMP may have been referring to. Regardless, I do not consider that it is necessary for me to make any finding with regard to the exact timing of this call, but only to note that it occurred at some time on the morning of Mr TMP's date of death.

23. It appears that Mr TMP subsequently commenced driving in the direction of Adelaide in his niece's vehicle, a black 2016 Hyundai Santa Fe station wagon.

24. At approximately 12.25pm, Mr TMP was travelling west along the Western Highway, Buangor. At this location, the Western Highway is a sealed road with two lanes, travelling in an east and west direction over a railway overpass between Colonial Road and Hillside Road. The overpass is narrow and approximately 9.3 meters in width, with two solid white lines dividing the lanes and surrounded by concrete and metal safety railings on either side. Trees and shrubs line both sides of the road, restricting visibility for vehicles travelling both directions as they travel through the road bends. The surrounding area is thick bush land and isolated rural properties with an operational railway line under the overpass. The sign posted speed limit for the road is l00km/h.

25. At that same time, 38-year-old Mr ELC was travelling east along the same stretch of the Western Highway in an Iveco Stralis Prime Mover, towing a dog trailer with two 20ft empty shipping container. Mr ELC's vehicle was also carrying one passenger, 37-year-old Mr GTV. Mr ELC and Mr GTV worked together at a furniture removalist company and were in the process of completing a job which involved the delivery of furniture to Pomonal. They had been driving from approximately 5.35am that morning and were on their way back to the depot in Laverton North at the time of the incident. Mr ELC noted that he was travelling at the speed limit, as the truck has a speed limit which prevents it from going faster.

26. Mr ELC described that as he entered the bend at the beginning of the railway overpass, he was driving in the centre of the east bound lane. He stated that "*[w]ithin a split second,*" he saw the Hyundai Santa Fe travelling "*completely in [his] lane*" toward him. He stated, "*I had no time or space to move out of the way.*" Mr ELC pressed the brakes and veered slightly to the right, but the Hyundai Santa Fe continued in his path and collided head-on with the Prime Mover.

27. The Prime Mover pushed the Hyundai approximately 32 metres east bound along the bitumen, until it came to rest straddling the top of the northern barrier. The Prime Mover veered over the northern barrier, travelling down an 8-metre embankment and coming to rest in the trees, 18.6 metres further to the east.

28. Soon after the collision, a number of unrelated vehicles passing by stopped to render assistance. No witness had directly observed the collision, although it had been heard by the occupants of three separate vehicles.

29. The first person to attend Mr TMP's vehicle observed that he was "*slumped over*" in the driver's seat and appeared to be unconscious. While he initially assumed that Mr TMP was deceased, he subsequently observed that Mr TMP appeared to be breathing.

30. A short time later, a number of other passersby had also arrived at the vehicle and Triple Zero (**000**) was called. While waiting for the arrival of Emergency Services, one passerby had brought a First Aid Kit to the vehicle and jumped onto the bonnet such that he could access Mr TMP through the front windscreen. He observed that Mr TMP appeared to have a "*slight pulse*" and significant bleeding from a large gash on the left side of his head. Using his First Aid Kit, he attempted to wrap Mr TMP's head using a bandage.

31. By this time, an off-duty paramedic had also arrived at the scene with a second First Aid Kit. Upon being notified that Mr TMP appeared to be alive, he rang the Ambulance Victoria Duty Manager to provide a situation report and request HEMS dispatch to the scene, along with Advanced Life Support crew and Mobile Intensive Care Ambulance. He then returned to the vehicle to provide further assistance.

32. The off-duty paramedic noted that the impact was severe and that Mr TMP was severely trapped, with access only available via the front windscreen. He stated that he initially felt "*a very faint pulse,*" but on his next review, could no longer palpate a carotid pulse. He attempted to use his stethoscope and blood pressure cuff to assess Mr TMP's blood pressure, but was unable to detect any signs of life.

33. Emergency services arrived shortly afterwards, including Ambulance Victoria, the Country Fire Authority (**CFA**), Victoria State Emergency Service (**SES**), and Victoria Police.

34. The off-duty paramedic provided a handover to Ambulance Victoria paramedics, indicating that there was no pulse as per his assessment. Ambulance Victoria paramedics then assessed the scene and determined that it was unsafe to perform a proper assessment until the CFA / SES had confirmed that the vehicle was adequately secured, due to a perceived risk of the vehicle slipping down the embankment.

35. Once secured, paramedics completed an assessment of Mr TMP using a cardiac monitor. It was determined to be an asystolic rhythm. Mr TMP was subsequently verified as deceased at the scene.[5]

36. Mr ELC and Mr GTV were assessed by paramedics and transported to the Ballarat Base Hospital for examination. They were both discharged shortly after with no significant injuries.

Police investigations

37. Victoria Police commenced an investigation immediately, which included a scene analysis, mechanical inspection, collision reconstruction, collecting statements from all witnesses, and conducting enquiries with regard to both drivers' histories and the events leading up to the incident.

Enquiries regarding any recent police contact

38. It was noted in the coronial brief that on the morning of his death, Mr TMP had told his Migration Agent that he had been driving all night and had been stopped by police, but did not have identification on him. Mr TMP stated that he had told police that he would return, but instead planned to leave the State and mentioned moving between Adelaide and Sydney.

39. In response to this disclosure, Victoria Police conducted enquiries but did not identify any evidence that Mr TMP interacted with police on the night prior to his death.

40. In particular, Victoria Police performed checks of relevant databases, as follows:

    a) There was no record of Mr TMP in either Victoria Police's internal database Law Enforcement Assistance Program (**LEAP**) or VicRoads records;

    b) Mobile phone call charge records indicated that Mr TMP remained within the Melbourne and surrounding area until he began making his way to Buangor where the collision occurred;

    c) An Automatic Number Plate Recognition (**ANPR**) vehicle search indicated that the last identification was on 3 November 2024.

[5]A paramedics providing treatment described, "*Given the time from the incident, the mechanism, the finding of asystole and the extensive entrapment of the patient precluding us from completing any resuscitative efforts, it was determined that he was deceased, and no further interventions took place.*"

41. Victoria Police did not identify any further reasonable lines of investigation.

Enquiries regarding Mr TMP's change of plans

42. Victoria Police made further enquiries with Mr DKA and Mr TMP's family as to their understanding of Mr DKA's plans on the day of his death.

43. Both Mr DKA, and Mr TMP's family, stated that they had understood that Mr TMP was planning to attend Mr DKA's wedding, which was to be held in Altona North on 19 November 2025. This was consistent with Mr TMP's conversation with Mr DKA at Sayers Road Barbershop the night prior.

44. However, it appears that at some point following this interaction, Mr TMP changed his plans and determined to drive to Adelaide instead of attending Mr DKA's wedding. Mr TMP did not mention to his family or friends any reason for this apparent change of plans.

45. Mr TMP's family attended the wedding without him. Sadly, Mr DKA and Mr TMP's family received notification of his death during the wedding reception.

Mechanical inspection

46. Senior Constable David Giulieri (**SC Giulieri**) of the Collision Reconstruction and Mechanical Investigation Unit was requested to conduct a mechanical inspection of the Hyundai.

47. Although the inspection was limited due to the extent of the damage caused by the collision, SC Giulieri confirmed there were no faults with the breaks. The accelerator pedal was mostly undamaged and operated freely without fault. Some components of steering and suspension systems could not be fully examined due to being damaged however the damage to these components was consistent with the damage caused in the collision. Of the remaining components, the examination found the damage consistent with the collision.

48. Overall, the mechanical inspection did not reveal any faults, failures or conditions that could have caused or contributed to the collision.

Victoria Police collision reconstruction

49. Detective Senior Constable Yuxing Zhao (**DSC Zhao**) of the Collision Reconstruction and Mechanical Investigation Unit was requested to complete a collision reconstruction.

50. DSC Zhao concluded that the Hyundai was travelling between 77km/h and 97 km/h at impact[6] and appeared not to have taken any evasive action including emergency braking or steering, maintaining its speed of 97 km/h with moderate and stable pressing to the acceleration pedal until braking was activated 0.5 seconds before the crash.

51. Although the speed of the Prime Mover was unable to be determined, there was no physical evidence at the scene to suggest that it was travelling at an excessive speed. Further, there was evidence that the Prime Mover had entered emergency braking and skidded to the impact.

52. DSC Zhao noted that the area of impact was in the eastern lane, adjacent to the northern fog line. This location suggested that the westbound Hyundai was "*well and truly*" in the eastbound lane at the time of the collision.

53. DSC Zhao further noted that it appeared that the Hyundai may have been travelling at least partially in the eastbound lane in the five seconds prior to the collision. This was on the basis that data from the Hyundai's Airbag Control Module (**ACM**) showed there was no steering input to the vehicle until one second before the crash, when a low-to-moderate level of steering input to the right began to be recorded. DSC Zhao noted if the Hyundai only crossed into the eastbound lane by the steering at one second before the crash, the Prime Mover would not have had sufficient time to engage its emergency braking prior to the impact, as it had done. As such, it was most likely the vehicle had already been travelling in the eastbound lane at the time it steered further right.

54. DSC Zhao observed that the Hyundai sustained a catastrophic impact to the front in the direction toward the rear, and the front section of the vehicle was crushed and torn apart. The firewall and the windscreen frame were pushed deep into the cabin which had little space remaining. The roof was compressed towards the rear. Both front and side airbags in the vehicle had deployed.

Other investigations in relation to the collision

55. Victoria Police members made other enquiries in relation to the collision, which confirmed:

[6] The impact speed was recorded as 77 km/h. However, DSC Zhao commented that values shown at time 0.0 could have been recorded slightly after the impact, and so in his opinion, the true impact speed was between 77 km/h (the speed at 0.0) and 97 km/h (the speed at 0.5 seconds before).

a) Mr TMP held a Republic of Lebanon Driver Licence and had not obtained a Victorian Driver Licence prior to the incident.

b) Mr ELC held a full and current Victorian Driver Licence with a Heavy-Combination endorsement, having held the endorsement for approximately 15 years.

c) A preliminary breath test administered to Mr ELC immediately following the incident showed no presence of alcohol. A preliminary oral fluid test administered to Mr ELC also showed no evidence of any illicit drug.

d) Toxicological testing of post mortem blood samples collected from Mr TMP did not detect any alcohol or other drug.

e) Mr ELC was an experienced and confident driver, having been employed as a truck driver and removalist for approximately eight years transporting and delivering furniture around the state. Mr ELC stated that he drove fatigue regulated heavy vehicles on standard hours and was required to carry a logbook. He had never had a previous accident.

f) Call charge records for Mr TMP's mobile phone showed that he was not on a phone call at the relevant time, although there was constant data use prior to and at the time of the collision. Mr TMP's mobile phone was downloaded and analysed but did not provide any evidence of relevance in investigating the circumstances of the collision.

g) The Prime Mover's dash camera footage was able to be retrieved for the minutes prior to the collision, although footage of the collision was unable to be retrieved. The footage of the minutes leading up to the collision gives no indication as to any possible cause, or contributing factor, to the collision.

h) At the time of the collision, the weather was fine, the road was dry, visibility was good, and traffic was medium.

Victoria Police conclusion

56. Following the completion of all investigations and enquiries, Victoria Police formed an opinion that the collision was contributed to by driver fatigue, distraction, and/or inexperience at driving a motor vehicle in Australia. In this respect, I note that drivers in Lebanon are required to travel on the right-hand side of the road.

Identity of the deceased

57. On 21 November 2024, Mr TMP, born [redacted] 1995, was visually identified by his niece.

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

Medical cause of death

59. On 20 November 2024, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post mortem computer tomography (**CT**) scan, the Victoria Police Report of Death (**Form 83**) and four scene photographs provided by Victoria Police. Dr Young provided a written report of his findings dated 27 November 2024.

60. The post mortem external examination revealed injuries to multiple areas of the body. No unexpected signs of trauma were identified.

61. The post mortem CT scan showed extensive fractures, subarachnoid and intraventricular haemorrhage in and around the brain, and gas in the head (pneumocranium), heart and liver, attributable to the fractured facial bones.

62. Toxicological analysis of blood was performed which did not detect the presence of any drugs or alcohol.

63. Dr Young provided an opinion that the medical cause of death was, '*1(a) Multiple injuries sustained in a motor vehicle incident (driver)*.'

64. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS

65. Following her investigations, the Coronial Investigator suggested the following possible prevention opportunities for my consideration:

    a) to reduce the speed limit of the relevant section of the road to 80km/hr; and

    b) have High Risk Area or High Accident Zone posted signs on the Western Highway in the east and west bound lanes.

66. In light of these suggestions, and taking into account all available evidence, I determined to refer this matter to the Coroners Prevention Unit (**CPU**) to review available data and research with regard to this area of road and provide advice on whether there may be any prevention opportunities arising out of the circumstances in this matter.

67. The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

68. In considering this advice, I note that there have since been safety measures identified and implemented by the Department of Transport and Planning as discussed further below.

Background – Western Highway upgrade between Buangor and Ararat

69. The need to upgrade the relevant section of the Western Highway a has been recognised for more than a decade.

70. In early 2008, substantial planning for the duplication of the Western Highway between Ballarat and Stawell began, and in August 2016 works on the 12.5km section of the highway between Buangor and Ararat commenced.[7] The plans included:

    c) Adding an extra lane in each direction;

    d) A new bridge over the Hopkins River;

    e) An interchange at Hillside Road, with entry and exit ramps.[8]

71. The plans were originally due to be completed in 2020 but remain incomplete as at today's date.

72. In considering the reasons for this delay, I have had regard to the comprehensive investigation of the Victorian Ombudsman, as outlined in its report titled, 'Investigation into the planning and delivery of the Western Highway duplication project'.[9]

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7 *See* Victorian Ombudsman, 'Investigation into the planning and delivery of the Western Highway duplication project', https://assets.ombudsman.vic.gov.au/assets/Reports/Parliamentary-Reports/Investigation-into-the-planning-and-delivery-of-the-Western-Highway-duplicationproject.pdf (hereinafter: '**Victorian Ombudsman Report**').

8 Victoria's Big Build, 'Buangor to Ararat', <https://bigbuild.vic.gov.au/projects/roads/western-highway-upgrade/sections/buangor-to-ararat>.

9 Victorian Ombudsman Report.

73. In summary, works associated with the duplication project were effectively halted in June 2018 in response to efforts to protect the site due to its apparent cultural significance for Djab Wurrung people.

74. Djab Wurrung people in opposition to the project raised criticisms that the natural features and contours of the area impacted by the approved highway alignment – including, but not limited to, two trees were which nominated as highly culturally significant 'birthing trees' used by Djab Wurrung ancestors when giving birth – were sacred according to Aboriginal tradition; and that the highway works would involve unacceptable impacts to cultural heritage in this area. These traditional owners also said they held concerns about the nature and thoroughness of the cultural heritage assessments conducted by VicRoads when the highway alignment was developed, as well as the extent of VicRoads' consultation with traditional custodians during this period.

75. Efforts to halt the project included the establishment of a protest camp, which came to be known as the 'Djab Wurrung Heritage Protection Embassy', as well as an application by several Djab Wurrung traditional custodians to the Commonwealth Government seeking protection of the project area under Commonwealth Aboriginal heritage protection legislation.

76. Following these issues being raised, VicRoads undertook a process of further consultation and cultural heritage assessment.

77. In approximately April 2019, a modified alignment was agreed, which would avoid 16 of the approximately 22 trees that have been identified as culturally significant, including the two 'birthing trees.' However, ongoing court proceedings meant that the project remained on hold.

78. In June 2022, the Victorian Government further announced its intention to develop a new Cultural Heritage Management Plan for the remainder of works on the Western Highway Upgrade, between Buangor and Ararat, working closely with the Traditional Owner group who have decision-making responsibilities for matters of cultural heritage protection in respect of the project area.

79. The Western Highway duplication project is yet to be recommenced.

CPU analysis

80. In the context of ongoing delays to the Western Highway duplication project, the CPU analysed the available data with regard to nearby collisions in order to assist me to understand the extent of any ongoing safety issues in this area.

81. Following a review of available data,[10] the CPU identified 34 non-fatal injury collisions and five fatal collisions on the Western Highway between Pope Road Buangor and Geelong Road Ararat since 1 January 2012.

82. Four of the fatal collisions were head-on collisions that occurred since November 2024, including the death of Mr TMP Hussein.[11] Eight of the non-fatal injury collisions were head-on collisions, and in seven of these at least one person sustained serious injuries. Three of the eight non-fatal head-on collisions occurred since January 2024 (noting that the non-fatal collision data is only up to November 2024).

83. The CPU also mapped the locations of the head-on collisions that occurred along the stretch of road (focusing on head-on collisions because this was the type of collision in which Mr TMP lost his life). Figure A shows the locations along the stretch of road, with non-fatal injury collisions in blue and fatal collisions in red.

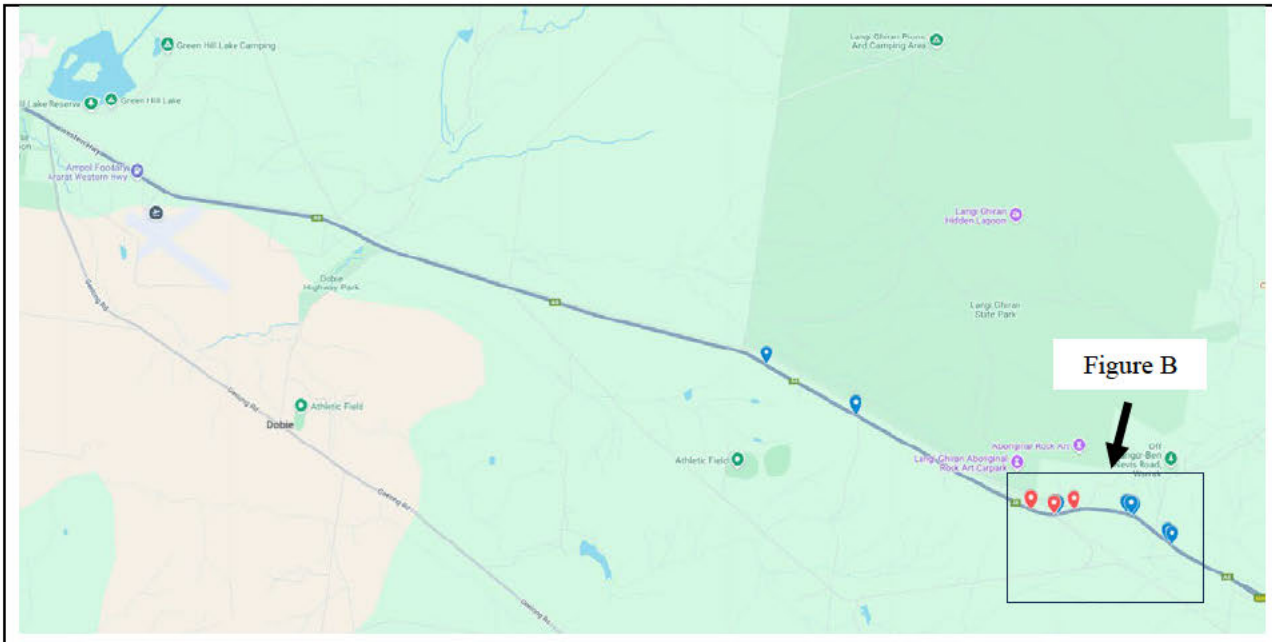

Figure A: Locations of non-fatal head-on injury collisions (in blue) and the fatal head-on collisions (in red) along the Western Highway between Pope Road Buangor and Geelong Road Ararat since 1 January 2012.

10 The CPU used the Court surveillance database to identify unintentional road collision fatalities that occurred on Western Highway, between Pope Road Buangor and Geelong Road Ararat, during the period 1 January 2012 to 30 July 2025. To identify non-fatal injury collisions along this same stretch of road, the CPU searched the Victorian Road Crash Data asset, which is published by the Victorian Department of Transport and Planning (**DTP**) under the auspices of the DataVic Access Policy (a government-wide policy to enable public access to government data) and contains information about injury collisions that have occurred across Victoria since 1 January 2012. The dataset has some limitations (including that it is published with a seven-month time lag and may be incomplete), however may still provide useful information for understanding where non-fatal collisions have occurred. The CPU noted that the most recent month of data in the Victorian Road Crash Data asset at the time of its analysis was November 2024.

11 The other three matters are subject to current coronial investigations with case numbers as follows: COR 2025 001299; COR 2025 003857; and COR 2025 004154.

84. As is clear from Figure A, most fatal and non-fatal head-on collisions occurred on a specific 3 km section of road in the south-east of the map, in Buangor. This is the section of the road where Mr TMP's collision occurred. Figure B zooms in on this section of road to show more detail about the head-on collision locations.

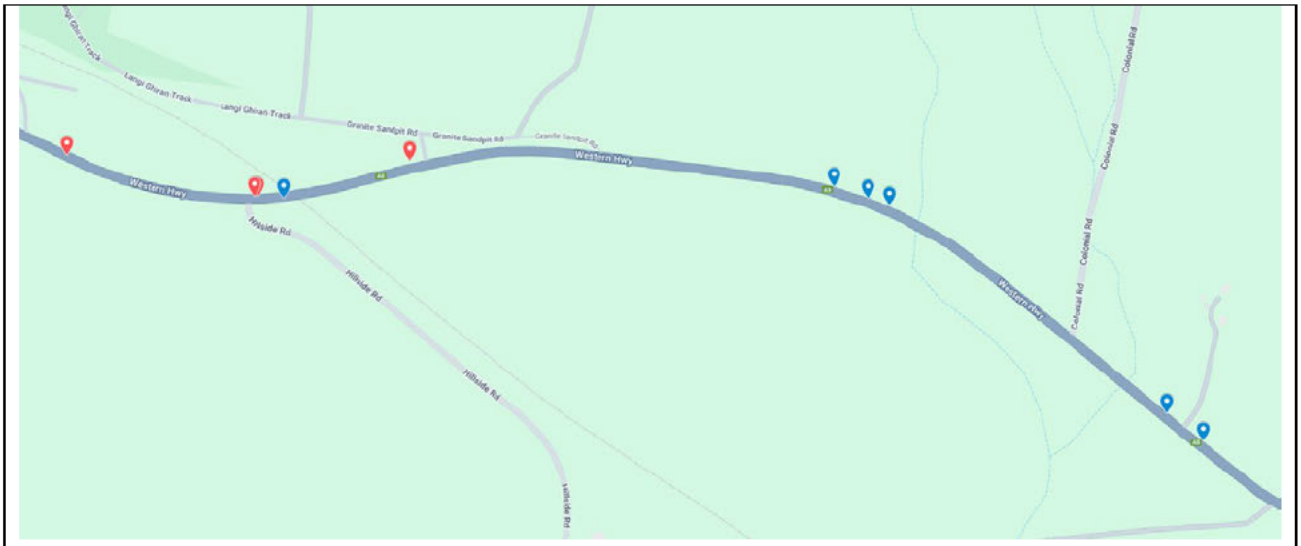

Figure B: Locations of non-fatal head-on injury collisions (in blue) and the fatal head-on collisions (in red) along the Western Highway west of Pope Road in Buangor since 1 January 2012.

Progress update on highway upgrade and safety measures

85. In light of the high number of recent fatal collisions, I sought an update from the Department of Transport and Planning with regard to the Western Highway duplication project and any other recent safety measures implemented.

86. As at 28 November 2025, the Department of Transport and Planning stated that:

a) The Victorian Infrastructure Delivery Authority (**VIDA**) is currently progressing a range of approvals for the Project, which includes the finalisation of a new Cultural Heritage Management Plan.

b) A decision from the Federal Minister in relation to protections under the *Aboriginal and Torres Strait Islander Heritage Protection Act 1984* is also pending until after the new Cultural Heritage Management Plan is approved.

c) The Department of Transport and Planning advised that VIDA Roads and its heritage advisors have been working closely with Eastern Maar Aboriginal Corporation, as the Registered Aboriginal Party, to finalise the new Cultural Heritage Management Plan for

the area, consistent with the requirements set out under the *Aboriginal Heritage Age 2006* (Vic) and *Aboriginal Heritage Regulations 2018* (Vic).

d) All construction works, other than those necessary to maintain the safety and security of the site, are on hold until the Cultural Heritage Management Plan is finalised and all other relevant approvals are obtained.

e) VIDA Roads is working to update and finalise the project's concept design, taking into account feedback from a range of stakeholders, while progressing the necessary approvals. The updated design balances the impact on Aboriginal cultural heritage, flora and fauna, land use, traffic requirements, noise quality and social impacts of duplicating the highway.

f) VIDA Roads acknowledges that the road duplication is vital for the safety of the community, and are continuing to work closely with stakeholders to progress the project.

g) While the project remains a priority for VIDA Roads, the approvals required to commence construction are subject to external factors outside of VIDA Roads' control. In light of this, the Department of Transport and Planning is unable to confirm the expected timeframe for the Cultural Heritage Management Plan finalisation, obtaining other necessary approvals, or when construction works will re-commence.

h) The revised completion date will be determined once all planning approvals have been obtained.

87. The Department of Transport also confirmed that in the meantime, a number of safety measures had been identified and implemented on the Western Highway between Buangor and Ararat. Specifically:

a) On or about 5 August 2025, the speed limit was reduced from 100km/h to 80km/h on an approximately 1.7km section of the highway in the vicinity of the Langi Ghiran rail bridge;

b) Supplementary 'High Risk Area' signage was added to speed zone signs and installed on or about 5 August 2025;

c) Approximately 1km of double barrier (solid) centrelines and Raised Reflective Pavement Markers was installed on or about 15 September 2025;

d) Five additional Curve Alignment Markers were installed on or about 15 September 2025, in addition to the four existing, in both directions in the vicinity of the road curve across the rail overpass; and

e) High friction road surface treatment (calcined bauxite) is to be installed on the west approach to the Buangor rail overpass (approximately 470m length) by May 2026 (subject to contract award).

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Mr TMP, born [redacted] 1995;

b) the death occurred on 19 November 2024 at Western Highway Buangor Victoria 3375, from *1(a) multiple injuries sustained in a motor vehicle incident (driver)*; and

c) the death occurred in the circumstances described above.

89. Having considered all of the circumstances, I consider that it is most likely that Mr TMP died as the result of a tragic accident, in which he encountered a head-on collision while mistakenly driving on the wrong side of the side. It is possible that Mr TMP's driving may have been contributed to by driver fatigue (noting that he had indicated to his Migration Agent that morning that he had been driving all night), distraction (including as a result of his distressed state associated with his visa status), and/or inexperience at driving a motor vehicle in Australia (whereby Mr TMP may have reverted to the road rules of Lebanon, where drivers travel on the right side of the road).

90. I note that there is some evidence to suggest that Mr TMP may have intended to end his life. In particular, Mr TMP presented to his Migration Agent that morning in a distressed state and made comments which may have indicated suicidal intent, stating, "*I've had enough*" and "*I'm tired of everything*." This was consistent with indications from his best friend, Mr DKA, that he was a "*little depressed*" in relation to this visa status. Mr TMP subsequently failed to attend his best friend's wedding and instead appears to have pursued a spontaneous plan to drive towards Adelaide, with no clear reasoning known to his family or friends. This behaviour may be suggestive of an erratic and distressed mindset. However, in absence of any positive evidence to confirm his state of mind at the time of the collision, I consider that there is insufficient evidence to make any finding of intent.

91. With regard to ongoing delays in upgrading the relevant section of the Western Highway from Buangor to Ararat, I am concerned by ongoing safety issues in this area and urge that the Victorian Government continue to prioritise the proposed upgrades. In this regard, I note that since the initial date for completion passed in 2020, four people have lost their lives in head-on collisions which occurred on the relevant stretch of road. There have also been a number of non-fatal injuries in head-on collisions additional to these deaths.

92. However, in making these comments, I recognise the fundamental importance of thorough and careful consultation in engaging with local Aboriginal people and organisations, to ensure that any final design minimises any deleterious impacts on Aboriginal cultural heritage. In this respect, I acknowledge the safety measures recently implemented in this area, including a reduced speed limit and improved signage, which I am hopeful may improve safety for those travelling between Buangor and Ararat until the highway duplication project is completed.

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

I acknowledge the ongoing and excellent efforts of my investigator, First Constable Larissa Gunn.

ORDERS AND DIRECTIONS

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.

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

Senior Next of Kin

Victorian Infrastructure Delivery Authority

The Department of Transport and Planning

Martha Haylett MP, local member for Ripon

First Constable Larissa Gunn, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 20 January 2026

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.