IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000185

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sara Dennis
Deceased:	Mather Adam Bell
Date of birth:	23 August 2006
Date of death:	9 January 2025
Cause of death:	1a: Drowning consequent upon submersion after a motor vehicle incident
Place of death:	3852 Hamilton-Port Fairy Road Macarthur Victoria 3286

INTRODUCTION

1. On 9 January 2025, Mather Adam Bell was 18 years old when he was found deceased following a motor vehicle collision. At the time of his death, Mather lived in Wannon with his family.

2. Mather is survived by his parents, Madeleine and Joshua, and siblings Hudson, Grady and Tatum.

Background

3. Mather was born in Broome and moved with his family to Wannon in Victoria when he was 14 years old. He attended Monivae College in Hamilton before leaving school in 2023 to pursue an apprenticeship as a diesel mechanic. He had plans to complete his apprenticeship and move to Western Australia to work on the mines. At the time of his death, he worked at Phillips Farm Machinery. He was described as an asset to his workplace.

4. Mather loved being with his mates and spending time outdoors. He enjoyed four-wheel driving, camping, hunting and fishing. He had two dogs, Cliff and Buster, whom he loved.

5. Mather drove a 2009 Holden Colorado dual cab utility vehicle (ute) that he purchased in November 2023. He obtained his probationary license in August 2024.

6. According to Joshua, Mather was a competent driver who wouldn't take any big risks. His best mate, Tom, said that Mather always wore his seatbelt and did not usually speed, but occasionally used his phone while driving. In December 2024, Mather had received a penalty notice for exceeding the speed limit by 15 to 24 km/h.

7. Mather had no known health issues. According to Tom, Mather was *"one of the happiest blokes [he] knew, you couldn't wipe the smile off his face"*.

THE CORONIAL INVESTIGATION

8. Mather'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 Senior Constable (**SC**) Zac Petrie to be the Coronial Investigator for the investigation of Mather's death. SC Petrie 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. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026 for the purpose of finalising the investigation and making findings.

13. This finding draws on the totality of the coronial investigation into the death of Mather Adam Bell including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

14. Mather stayed with his family at the Gardens Caravan Park in Port Fairy from 27 December 2024 to 9 January 2025, during which he had been driving between Port Fairy and his workplace in Hamilton.

15. Mather left the campsite for work at around 7am on 9 January 2025. There was nothing out of the ordinary with his demeanour.

[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.

16. Mather left work at around 5pm and returned to his home in Wannon. At around 5:15pm, he spoke to his father and told him was about to leave home to return to Port Fairy. Mather also spoke to Tom and told him he would be at the campground at around 7pm.

17. At around 6pm, Mather sent a Snapchat to Tom. The photo showed Mather's speedometer at 105km/h. Mather was sent a Snapchat by a friend at 6:32pm which was not opened or replied to. Snapchat has a 'Snap Map' feature which shows the user's location to their friends while the app is in use. Mather's location last updated when he sent the Snapchat to Tom.

18. At around 7:45pm, Linton Price, Captain of the Broadwater Fire Brigade, noticed black tyre marks on Hamilton-Port Fairy Road. He looked across the road and saw a vehicle submerged in a small pond/dam adjoining Snakey Creek, used as a fill point for brigade's fire trucks. He immediately called Fire Command. The vehicle, a Holden ute, was upturned and approximately 75 per cent submerged, with the driver's side submerged in the water.

19. Emergency services personnel from multiple agencies arrived at the scene soon after. It was determined to be unsafe to enter the water, and the decision was made to await the arrival of the Victoria Police Search and Rescue Squad.

20. Search and Rescue attended in the early hours of 10 January 2025. Senior Constable Joseph Gray located the body of a man, later identified to be Mather, in the driver's seat of the ute, still wearing his seatbelt. He was extracted from the water and declared deceased.

Identity of the deceased

21. On 11 January 2025, Mather Adam Bell, born 23 August 2006, was visually identified by his family friend, Paul Murrihy, who completed a Statement of Identification.

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

Medical cause of death

23. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Mather Bell on 13 January 2025 and provided a written report of her findings dated 14 January 2025.

24. The post-mortem CT scan showed no skull fracture or intracranial haemorrhage. The cervical spine was intact. There was no skeletal trauma. There was a patchy increase in lung markings.

25. The external examination showed a frothy oral plume and no external injuries of note.

26. Dr Glengarry noted that there was no evidence of traumatic injury as a cause of death.

27. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or other common drugs or poisons.

28. Dr Glengarry provided an opinion that the medical cause of death was *1(a) Drowning consequent upon submersion after a motor vehicle incident.*

29. I accept the opinion of Dr Glengarry as to the cause of death.

VICTORIA POLICE COLLISION INVESTIGATION

30. At the time of the collision, it was daylight with clear conditions and the road was dry. At the collision location Hamilton-Port Fairy Road has a speed limit of 100 km/h. However, before entering the first bend before Kangertong Road there is a speed advisory sign of 80 km/h with black and yellow right chevrons indicating the bend in the road.

31. The evidence indicates that Mather was travelling south on Hamilton-Port Fairy Road when his ute travelled on to the left shoulder, prior to Kangertong Road, leaving rolling tyre prints. It continued on the shoulder towards south of Kangertong Road for approximately 41.5 metres before abruptly curving to the right. The ute then yawed across Hamilton-Port Fairy Road for approximately 26.5 metres, before continuing to the nature reserve on the western side of the road. Approximately 32 metres after leaving the road surface, the ute entered Snakey Creek. It continued 12.8 metres across the water before striking the bank on the southwestern side.

32. Detective Leading Senior Constable Timothy Bell of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) reviewed the collision. He opined that, for an unknown reason, Mather's ute failed to stay on the bitumen surface and travelled on to the dirt shoulder to the outside of a right-hand bend. Mather responded by making an excessive right steering input, which resulted in loss of control.

33. Leading Senior Constable Brett Gardner from the CRMIU conducted a mechanical examination on Mather's ute. Due to the severity of damage to the vehicle, he was unable to draw any conclusions in relation to the severely damaged components, including the electronic components of the braking system and manual and power assistance operation of the steering components. However, of what he was able to examine, he found no faults or failures of conditions which would have caused or contributed to the collision.

ROAD CONDITION

34. The evidence before the Court indicated that there is a 'dip' in the road surface of Hamilton-Port Fairy Road after the 80 km/h advisory sign. Coronial Investigator Senior Constable Zac Petrie noted that he drove over this dip at 100 km/h, causing significant lift on the divisional van. Broadwater CFA Captain Linton Price also mentioned the dip in the road in his statement as part of the Coronial Brief. He described the road as *"shocking"* and stated that several motorists had ended up in the dam, including one that had died.[2]

35. The Court requested a statement from the Department of Transport and Planning (**the Department**) addressing the collision location, any road works undertaken or planned for the relevant section of road, and whether there had been any prior incidents at the location. In addition, Coronial Investigator SC Petrie provided footage from within a vehicle driving the relevant portion of road.

36. The Department advised that Hamilton-Port Fairy Road is designated Road Maintenance Category 4, meaning it is inspected once per fortnight. A review of the Department's records indicated that there had been zero 'injury collisions'[3] reported for 1 kilometre either side of the location, for the five-year period to 31 December 2024.

37. The Department advised that a Fatal Crash Report had been made following Mather's death, which suggested that "*Safety barrier at the 'fire dam' may have provided protection from roadside hazard/s",* and that this suggestion is being investigated. The Fatal Crash Report did not mention a dip in the road.

38. It is difficult to make an accurate assessment of the condition of the road through reviewing statements and multimedia. However, I note the opinion of local emergency services personnel that the current road condition may pose a risk to road users. Accordingly, I will make a recommendation to the Department of Transport and Planning that they consider what safety improvements could be made.

[2] A search of Court data did not identify any previous fatalities at the same location.

[3] Includes fatal, serious or other injury-related crashes.

RECOMMENDATIONS

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

(i) In the interests of preventing like deaths and promoting public health and safety, I recommend the Department of Transport and planning consider whether additional safety measures could be implemented on Hamilton-Port Fairy Road at Macarthur, for example by installing signage alerting road users to a decline in the road surface, and reminders about the speed limit.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Mather Adam Bell, born 23 August 2006;

   b) the death occurred on 9 January 2025 at 3852 Hamilton-Port Fairy Road, Macarthur, Victoria 3286;

   c) the cause of Mather's death was drowning consequent upon submersion following a motor vehicle collision; and

   d) the death occurred in the circumstances described above.

2. Having considered the available evidence, I find that the most likely cause of Mather's vehicle becoming submerged in a body of water was a moment of inattention or distraction while travelling slightly in excess of the speed limit (at around 105 kilometres per hour).

3. It is unclear why Mather did not extricate himself from his vehicle once it became submerged in the small pond/dam adjoining Snakey Creek but possibilities include concussion, entrapment or adverse position.

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

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:

Joshua and Madeleine Bell, Senior Next of Kin

Department of Transport and Planning

Senior Constable Zac Petrie, Coronial Investigator

Signature:

Coroner Sara Dennis

Date: 25 August 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.