IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004915

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Angelo Angelino
Date of birth:	4 September 1990
Date of death:	16 September 2021
Cause of death:	1(a) HEAD INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Motor vehicle collision, motorcycle collision, criminal proceedings, traumatic head injury

INTRODUCTION

1. On 16 September 2021, Angelo Angelino ('Angelo') was 31 years old when he died at the Royal Melbourne Hospital from injuries sustained when his motorcycle collided with a car. At the time of his death, Angelo lived at 4 Ironbark Way, Brookfield, Victoria.

2. Angelo worked in construction and had been a state champion boxer in his younger days. He had close relationships with his extended family and was also close to his former partner, Tammy Leadbetter. There were no know financial stressors in Angelo's life, nor mental or medical conditions that might have affected his judgement or driving.[1]

THE CORONIAL INVESTIGATION

3. Angelo'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Angelo's death. The Coroner's 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.

7. This finding draws on the totality of the coronial investigation into the death of Angelo Angelino 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

[1] Statements of Lehna Angelino & Tammy Leadbetter, Coronial Brief.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

8. In considering the issues associated with this finding, I have been mindful of Angelo's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

9. The collision occurred at approximately 6:38 am on Wednesday 10 February 2021.[3] This was not long after dawn and many vehicles still had their lights activated. At the time of the collision, the road was dry, the weather was fine, traffic was light and visibility was good.

10. The collision occurred in a 'keep clear' zone on the eastbound side of Ballarat Road, Deer Park, adjacent to a break in the median strip for westbound traffic to turn right across the three lanes of eastbound traffic into a service lane which is the entrance to Saint Peter Chanel Catholic Church and Primary School. Eastbound and westbound traffic along Ballarat Road is separated by a grass and landscaped median strip surrounded by concrete curbing. Immediately to the west of this keep clear zone is a pedestrian crossing operated by traffic control signals.[4]

11. The speed limit for the eastbound traffic applicable to the direction in which Angelo was travelling is clearly signposted at 70 kilometres per hour.[5]

12. Angelo held a Victorian driver's licence which had various conditions attached, including that he was not permitted to drive a motorcycle other than a Learner Approved Motorcycle.[6] He had nonetheless been riding motorcycles for more than 20 years and had owned several motorcycles previously without being involved in collisions or traffic convictions. He had

[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] Statement of Michael Hardiman, Coronial Brief.
[4] Ibid.
[5] Ibid.
[6] Exhibit 6, Coronial Brief.

however received eight speeding infringement notices between 2012 and 2021, although none of them involved this particular motorcycle. [7]

13. On 10 February 2021, Angelo was driving a black and grey coloured 2018 Harley Davidson registration 2A5HH.[8] This motorcycle has a powerful engine, with a cubic capacity of 1754 cc, and was not a Learner Approved Motorcycle. Although he had purchased the motorcycle two weeks before the collision, he had not yet completed the VicRoads transfer of registration.[9] Angelo was wearing an open-faced helmet which displayed a sticker indicating the helmet complied with Australian Standard AS/NZS 1698. The helmet was manufactured by 'Bell' and displayed an additional 'Warning' sticker referring to the Australian Standard. The additional sticker stated, 'The Bell Rogue helmet features a lower comfort shroud. This lower shroud is not added for safety'. It is unclear if compliance was achieved only when the shroud was fitted, or if the helmet as worn by Angelo no longer complied without the shroud.[10]

14. At the time of the collision, Angelo was riding from home to work, travelling in the right-most eastbound lane of Ballarat Road.

15. Ms Nonna Alberto, who also held a full Victorian driver's licence, was travelling westbound on Ballarat Road in the right-most lane and came to a stop at the break in the median strip immediately south of the 'keep clear' area, but east of the pedestrian crossing. The traffic control signals at the pedestrian crossing were operating at the time, but displaying a red stop symbol applicable to pedestrians. There were no pedestrians using the crossing at the time. [11]

16. Ms Alberto was driving a blue 2005 Toyota Corolla sedan and had her vehicle's lights on at the time. She had waited for seven other motor vehicles to pass before she pulled out to cross the eastbound lanes, intending to drive into the service lane for the church. In doing so, she pulled out into Angelo 's oncoming path, and his motorcycle struck the passenger side of her car.[12] The impact caused the car to spin around. Angelo was ejected from his motorcycle and landed on the road surface. The motorcycle fell onto its side and came to rest 10.3 metres from the point of impact. Both vehicles suffered significant damage.[13]

[7] Appendices 1 & 2, Coronial Brief.
[8] Exhibit 4, Coronial Brief.
[9] Statement of Mark Wood, Coronial Brief.
[10] Photographs 14, 15, 16, Coronial Brief.
[11] Record of Interview of Nonna Alberto, Exhibit 10, Coronial Brief.
[12] Ibid.
[13] Statement of Michael Hardiman, Coronial Brief.

17. Numerous witnesses stopped at the collision scene to provide assistance and contacted 000. Off duty nurse Samila Sadikovic performed cardiopulmonary resuscitation until Ambulance Victoria members arrived.[14] Although Angelo's vital signs were unrecordable at the time, he was triaged promptly to the Royal Melbourne Hospital.[15] He was stabilised at hospital, however his consciousness never returned. After seven months with minimal signs of improvement, his family transitioned him to palliative care where he passed at approximately 1:30 am on 16 September 2021.[16]

18. During the accident reconstruction process, Angelo's speed was estimated to be at least 107 kilometres per hour.[17] No skid marks from either vehicle were visible at the scene,[18] but my investigator did observe that the fencing near the pedestrian crossing partially obstructed the visibility of oncoming vehicles travelling east on Ballarat Road when viewed from the perspective of a car performing the manoeuvre undertaken by Ms Alberto in this collision.[19]

19. Both vehicles were inspected and not found to have any relevant mechanical faults.[20]

Identity of the deceased

20. On 16 September 2021, Angelo Angelino, born 4 September 1990, was visually identified by his sister, Lehna Angelino.

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

Medical cause of death

22. Senior Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 20 September 2021 and provided a written report of her findings that same day.[21]

23. The examination revealed injuries consistent with the history of the collision and the subsequent medical treatment. It did not identify any significant intervening event which might have contributed to the cause of death.

[14] Statements of Samila Sadikovic & Cassandra Portoglou, Coronial Brief.
[15] Appendix 3, Coronial Brief.
[16] E-Medical Deposition Form authored by Dr Kenneth Ng, Royal Melbourne Hospital, dated 16 September 2021
[17] Statement of Michael Hardiman, Coronial Brief.
[18] Ibid.
[19] Statement of Mark Wood, Coronial Brief.
[20] Statement of Dale Woodland, Coronial Brief.
[21] Exhibit 3, Coronial Brief.

24. Toxicological analysis of both post-accident[22] and post-mortem[23] samples identified the presence of substances consistent with the history of medical treatment, and did not identify the presence of any alcohol or other commons drugs or poisons.

25. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) head injuries sustained in a motor vehicle collision.

26. I accept Dr Glengarry's opinion.

CRIMINAL PROCESS

27. Ms Alberto was charged with the summary offence of failing to give way at an intersection. She was 69 years old at the time of the collision had no criminal convictions and only one other traffic infringement notice, which was from more than ten years prior. She pleaded guilty and was convicted and fined.[24]

INFRASTRUCTURE REVIEW

28. Having made the line-of-sight observations described above, my investigator sought historical information from the Department of Transport, who confirmed that there had been five injury collisions proximate to this one within the previous five years, albeit none in strikingly similar circumstances.[25]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Angelo Angelino, born 4 September 1990;

    b) the death occurred on 16 September 2021 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from HEAD INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION; and

    c) the death occurred in the circumstances described above.

[22] Exhibit 1, Coronial Brief.
[23] Exhibit 2, Coronial Brief.
[24] Statement of Mark Wood, Coronial Brief.
[25] Statement of Jan Wong and appendices 13 & 14, Coronial Brief.

30. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[26]

31. Having considered all of the evidence, I am satisfied that the collision was not the result of an intentional act by either driver.

32. I find that Angelo contributed to the collision, and consequently to his own death, by:

    a) riding a non-approved motorcycle in breach of his driver's licence conditions; and

    b) travelling at least 37 kilometres per hour above the posted speed limit on the road.

33. I find that Ms Alberto contributed to the collision, and consequently to Angelo's death, by making a poor decision to proceed into the intersection where the collision occurred.

34. I find that a full-face motorcycle helmet may have reduced the head injuries sustained by Angelo.

RECOMMENDATIONS

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

(i) I recommend that the Department of Transport and Planning review the intersection of Ballarat Road and the Ballarat Road Service Road, Deer Park, including the pedestrian crossing, 'keep clear' zone and break in the median strip, and consider updating the road design to enhance safety for motorists and pedestrians.

(ii) I recommend that open-faced motorcycle helmets without jaw protection be strongly discouraged by VicRoads, the Transport Accident Commission, motorcycle clubs and motoring groups, for all motorcycle riders utilising highways and at any official motoring functions, or competitions.

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

[26] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

Pursuant to section 73(1B) 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:

Tammy Leadbetter, Senior Next of Kin

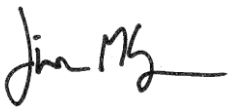
Lehna Angelino, Sister

VicRoads

Transport Accident Commission

Paul Younis, Secretary to the Department of Transport and Planning

Leading Senior Constable Mark Wood, Coroner's Investigator

Signature: 

_____CORONER SIMON MCGREGOR

Date : 23 January 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.