| IN THE CORONERS COURT<br>OF VICTORIA<br>AT MELBOURNE | **COR 2020 001547** |
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**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Simon McGregor |
| Deceased: | Nami Nakao |
| Date of birth: | 3 June 1997 |
| Date of death: | 18 March 2020 |
| Cause of death: | 1(a) Multiple injuries in a truck versus cyclist incident |
| Place of death: | St Kilda Junction, St Kilda, Victoria, 3182 |
| Keywords: | Vehicle collision, truck, cyclist, road safety design, bicycle lane, road upgrade project |

## INTRODUCTION

1. On 18 March 2020, Nami Nakao was 22 years old when she died from injuries sustained when a truck collided with her as she was cycling. At the time of her death, Nami lived at 6/82 Grey Street, St Kilda with her husband, Santiago Perez.

2. Nami was born in Japan and had been in Australia since June 2018 on a student visa, studying for a diploma of travel and tourism. Nami had no extended family in Australia, with her parents living in Japan and a brother living in New Zealand. Nami had ridden her bicycle along St Kilda Road almost daily since May 2019, as both her studies and work as a waitress were in the Melbourne CBD.

## THE CORONIAL INVESTIGATION

3. Nami'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 Nami'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 Nami Nakao 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]

8. In considering the issues associated with this finding, I have been mindful of Nami'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, pursuant to section 67(1)(c) of the Act

9. The fatal collision occurred on St Kilda Road, St Kilda, in the vicinity of the Queens Road on-ramp. The road at the collision site is a two-way road running generally north-south. The north-bound lanes consisted of three straight lanes and a left turning lane for the on-ramp to Queens Road. Between the left turning lane and the three straight lanes was a dedicated bicycle lane which also continued straight through the intersection. The bicycle lane was coloured green and marked with white painted bicycles on the road surface and bordered on both sides by a solid white line. The solid white lines bordering the bicycle lane were unbroken for approximately 150 metres south of the turn-off to Queens Road, meaning that for a vehicle to enter the left turning lane legally, it would need to do so prior to the solid white lines, some significant distance before the intersection.[2]

10. Approximately 75 metres south of the Queens Road turn-off is the intersection of St Kilda Road with Fitzroy Street, which runs to the southwest, and Punt Road which curves to the north. It is a very large and complex intersection, controlled by traffic lights. The stop line applicable to north bound traffic at this intersection is approximately 122 metres south of the turn on to Queens Road.

11. On Wednesday 18 March 2020, conditions were fine and sunny, the road was dry and visibility good.[3] Nami had left her home in St Kilda and was riding her bicycle north along St Kilda Road in the dedicated cycling lane. As she approached the intersection of Fitzroy Street at

[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.

[2] Statement of Detective Leading Senior Constable Thomas Heath dated 27 October 2020, Coronial Brief p.134.

[3] Ibid., p.134; Statement of Detective Leading Senior Constable Michael Hardiman dated 29 April 2020, Coronial Brief p.116;

approximately 1:38 pm, the north bound traffic on St Kilda Road was facing a red light and traffic was stationary.[4]

12. Mr Ted Sheather was also driving north along St Kilda Road in a white 2011 Kenworth Prime Mover towing a 2006 Haulmark 3ST37 trailer, which was not loaded. Mr Sheather was aged 29 years at the time of the collision and held a current Victorian driver's licence, which was endorsed to drive a multiple combination.[5] He had been a truck driver for approximately ten years but had been working primarily in Geelong and did not often drive in Melbourne. At the red light, his truck was positioned in the left-most of three straight traffic lanes, to the immediate right of the bicycle lane.[6]

13. As Nami approached the intersection, the lights turned green and she continued north through the intersection in the bike lane. The traffic and Mr Sheather also began moving into the intersection, and Mr Sheather activated his left turning signal and slowed down to wait for a gap in the turning lane traffic, which had several vehicles within it who were in line to turn left onto Queens Road. A black Mercedes van, driven by Anand Lohchab, slowed to allow Mr Sheather's truck room to move across into the turning lane.[7]

14. Mr Sheather continued forward, his vehicle moving to be adjacent to Nami, who was continuing in the bicycle lane. Mr Sheather then turned his vehicle to the left, across the bike lane and into the left turn lane. As he did so the front passenger side drive tyre of the prime mover collided with Nami and her bicycle, knocking her to the ground and causing grievous injuries. The collision was witnessed by several other motorists who gave their accounts of the collision to police.[8]

15. Mr Sheather stopped his truck on the Queens Road on-ramp and walked back to the collision site.[9] Several people stopped their vehicles to assist Nami and called 000.[10] Ambulance Victoria members were on the scene within minutes, [11] but Nami sadly died at the scene.

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[4] Coronial Brief, statement of Anan Lohchab dated 18 March 2020, p.33.
[5] Coronial Brief, VicRoads Certificate under section 84(1) of the *Road Safety Act 1986*, p.232.
[6] Record of interview of Ted Sheather, 18 March 2020.
[7] Coronial Brief, statement of Anan Lohchab dated 18 March 2020, p.33; Record of interview of Ted Sheather, 18 March 2020.
[8] Coronial Brief, statement of Anan Lohchab dated 18 March 2020, p.33; statement of Peter Forrest dated 18 March 2020, p.38; statement of Barry Kelly dated 18 March 2020, p.43; statement of Renee Stephens dated 20 September 2020, p.55; statement of Weiben Zhang, dated 17 August 2020, p.59.
[9] Record of interview of Ted Sheather, 18 March 2020.
[10] Coronial Brief, statement of Anan Lohchab dated 18 March 2020, p 33;
[11] Coronial Brief, statement of Renee Stephens, dated 20 September 2020, p.55; statement of Weiben Zhang, dated 17 August 2020, p.59; statement of Jordan Mirabelli dated 18 March 2020, p.72.

16. Officers from the Victoria Police Major Collision Investigation Unit, Heavy Vehicle Unit and Collision Reconstruction Unit attended the collision site and examined, measured, photographed and 3D scanned the scene.[12]

17. Police also video-recorded a walk-through of the scene and obtained CCTV footage from nearby businesses and traffic control cameras.

18. Detective Leading Senior Constable Michael Hardiman, a collision reconstructionist, provided a report of his findings based on the available evidence and concluded *inter alia* that Nami's bicycle was wholly inside the designated bicycle lane at the time of the collision. He was unable to determine the speed of the truck at the time of collision.[13]

**Identity of the deceased, pursuant to section 67(1)(a) of the Act**

19. On 20 March 2020, having considered the *Police Report of Death (Police Form 83)*, Victorian Institute of Forensic Medicine (VIFM) Identification Report and admission photograph of the deceased, the initial family contact log and identification located on the deceased's body by police members at the scene, Coroner Sarah Gebert determined the identity of the deceased to be Nami Nakao, born 3 June 1997.

20. In reaching this conclusion, her Honour was persuaded by the cogency and consistency of all the evidence relevant to identification.

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

**Medical cause of death, pursuant to section 67(1)(b) of the Act**

22. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 19 March 2020 and provided a written report of his findings dated 23 March 2020.

23. The post-mortem examination and computed tomography (**CT**) scan revealed extensive injuries consistent with the history of a vehicular collision.

24. Toxicological analysis of post-mortem blood samples did not identify the presence of alcohol or any commons drugs or poisons.

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[12] Statement of Detective Leading Senior Constable Thomas Heath dated 27 October 2020, Coronial Brief p.135

[13]

25. Dr Burke provided an opinion that the medical cause of death was 1(a) multiple injuries in a truck versus cyclist incident.

26. I accept Dr Burke's opinion.

## CRIMINAL PROCEEDINGS

27. Following the collision, Mr Sheather was taken to the Prahran Police station where a blood sample was taken from him pursuant to section 55BA of the *Road Safety Act 1986* at 3:30pm.[14] Analysis of the blood sample did not identify the presence of alcohol or any common drugs or poisons.[15] He was then arrested and remained at the station for interview.

28. At interview, Mr Sheather stated that he had taken that route eight or ten times and agreed that he was aware there was a bike lane between the turning lane and the through lane, but said he was unsure whether it went across the intersection. He told police that he had not seen the cyclist at all. He stated that he had not been looking for cyclists, but was looking in his mirrors to see if a car would let him into the turning lane, using the standard side mirror and the smaller convex mirror on the passenger side, and was aware of blind spots on the passenger side of the vehicle.[16] It remains unclear why Mr Sheather did not see Nami in the bicycle lane.

29. Mr Sheather was subsequently charged and pleaded guilty to one charge of dangerous driving causing death contrary to section 319(1) of the *Crimes Act 1958*.

30. In the course of the criminal proceedings, legal representatives on behalf of Mr Sheather tendered a report authored by Dr Shane Turner, a road design expert. In his report, Dr Turner describes in detail Victoria's 'Safe System' approach to road safety, which operates on the basis of four pillars: safe roads (including road design and maintenance), safe speeds, safe vehicles, and safe people (road users are skilled, competent, alert and unimpaired). Dr Turner opined that the collision that resulted in Nami's death could have been prevented by changes in a number of areas, including safer road design for cyclists, as well as safer driving by obeying the road rules and not crossing the bicycle lane where there was a solid line. Dr Turner expressed significant concerns about the 'poor quality of the cycle (and pedestrian) facilities through the junction', stating they were 'far from being Safe System aligned' and that cyclists should not have been 'in between two active traffic lanes for such a long length

[14] Certificate of the taking of a blood sample, Coronial Brief, p 226.
[15] VIFM Toxicology Certificate of Approved Analyst, dated 6 April 2020, Coronial Brief, p 228.
[16] Record of interview of Ted Sheather, 18 March 2020.

of road, particularly on a road where there are such high traffic volumes and lots of weaving taking place.'[17]

31. In submissions on sentence indication, the prosecution accepted that changes could be made to the intersection to make it safer and more in line with the 'Safe System' philosophy referred to in Dr Turner's report.[18]

32. Mr Sheather was sentenced in the Supreme Court of Victoria by Her Honour Justice Hannan on 27 April 2023 and was placed on a community corrections order for a period of three years. That order included conditions requiring supervision, mental health assessment and treatment, and 450 hours of unpaid community work.

## FURTHER INVESTIGATIONS AND VIEW

33. In July 2023, I made a request to the Department of Transport and Planning (**the Department**) for information relating to any remediations that had been made to the intersection since the date of the collision. The Department confirmed[19] that an extensive bike lane upgrade project was underway along a 4.5 km section of St Kilda Road, including the location of the collision that resulted in Nami's death.

34. In a letter dated 4 August 2023, Mr Adrian Furner, Program Director of the Major Road Projects Victoria[20] provided an outline of the largely completed project, which relevantly included:

    a) building separated kerbside bike lanes with bike markings along St Kilda Road (including at the intersection);

    b) installing coloured bike lane surfacing at conflict points, and bike boxes and bike lanterns at traffic light intersections to provide better visibility and priority movement for cyclists; and

    c) modifying traffic signals to provide additional priority for cyclists.

35. Specifically, the project involved relocating the bike lane located on St Kilda Road near the Queens Road turn-off, which was situated between the left turn lane and the through traffic

[17] Report of Dr Shane Turner, dated 1 February 2023, p 8.
[18] Outline of prosecution submissions on sentencing indication, 17 February 2023; *DPP v Sheather* [2023] VSC 219 (27 April 2023).
[19] Email from Amy Harrison, Department of Transport and Planning, dated 21 June 2023.
[20] Part of the Major Transport Infrastructure Authority

lanes at the time of the collision, to a kerbside bike lane that is physically separated from motor vehicle traffic by raised concrete ‘bumpers’. Traffic lights have also been added to control the flow of both cyclists and motor vehicles where the left-turning traffic lane onto Queens Road and the continuation of the bicycle through-lane unavoidably intersect.[21]

36. To better understand the remediations described by the MRVP, I conducted an in-person view of the intersection on Monday 28 August 2023. I was assisted by my registrar, who had past experience of using the intersection as a cyclist and recalled the previous lane configuration which often resulted in motorists crossing the bicycle through-lane to get to the left turning lanes onto Queens Road.

37. I walked through the intersection twice, noting the changes to lane markings and traffic flows, as well as new traffic lights that have been added to control the flow of both cyclists and motor vehicles where there is an unavoidable intersection of the left-turning vehicle lane onto Queens Road and the continuation of the bicycle through-lane.

## FINDINGS AND CONCLUSION

38. 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.[22]

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

    a) the identity of the deceased was Nami Nakao, born 3 June 1997;

    b) the death occurred on 18 March 2020 at St Kilda Junction, St Kilda, Victoria, 3182, from multiple injuries in a truck versus cyclist incident; and

    c) the death occurred in the circumstances described above.

40. Having considered all of the circumstances, I am satisfied that Nami’s death was the unintended consequence of Mr Sheather’s truck colliding with her as she rode her bicycle.

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[21] Letter from Adrian Furner, Program Director Major Road Projects Victoria to Coroners Court of Victoria, dated 4 August 2023

[22] *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…’.

41. I find that the collision resulted in part from Mr Sheather failing to keep a proper lookout when navigating a lane change, which was also in contravention of the lane markings controlling traffic at the intersection.

42. I find that a significant additional contributor to the collision was the poor road safety design at the intersection at the time of the incident.

43. On the basis of my observations at the view and the remediations described by Mr Furner in his response on behalf of the MRVP, I am satisfied that significant road design improvements have been made since the time of Nami's death, and that the completed remediations appear to mitigate, as far as possible, the risk of future similar accidents at an intersection that has unavoidably complex traffic flows.

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

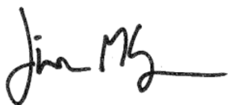
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

**Santiago Perez Portal, Senior Next of Kin**

**Leading Senior Constable Heath Thomas, Coroner's Investigator**

Signature:



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Coroner Simon McGregor

Date : 18 April 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.