IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4527

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Alfred Norman Avage

without holding an inquest:
find that the identity of the deceased was Alfred Norman Avage
born on 13 May 1935
and the death occurred on 4 September 2014
at the Alfred Hospital, 45 Commercial Road, Melbourne, Victoria
from:

1 (a) head injuries sustained in a fall from a bicycle

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Alfred Norman Avage was 79 years of age at the time of his death. He resided at Briagolong, Victoria, with his wife of 54 years, Isobel. Mr and Mrs Avage have two adult sons.
2. Mr Avage was a retiree and avid bicycle rider who would ride approximately 200-250 kilometres per week, often with a social riding group.
3. Victoria Police conducted an investigation into the circumstances of Mr Avage's death and provided a coronial brief. The brief includes statements obtained from Mrs Avage, witnesses to the fall, attending paramedics and the coroner's investigator. I have drawn on all of this material as to the factual matters in this finding.

Health History

4. Mrs Avage reported that Mr Avage was physically fit and, apart from occasional blood pressure issues, was very healthy.

Events Proximate to Death

5. At approximately 9am on 3 September 2014, Mr Avage met with a group of 11 cyclists for an informal, social ride around the district. The weather was fine and visibility was good. The group rode from Stratford to Boisdale, Newry and Heyfield before stopping at a bakery for approximately 30 minutes. After the rest break, the group rode back to Maffra. Mr Avage took turns leading the group during this section of the ride. At Maffra, the group rode down Norden's Lane, heading east.

6. Norden's Lane is a minor bitumen road, primarily used for resident access, heavy vehicles and agricultural machinery. There is an 'S' bend in the road and a relatively steep descent about 300 metres before the end of the road. The road at the base of the descent, where a gravel driveway meets the road, was partly covered by mud, debris (gravel) and water at the time of the incident.

7. As the group descended Norden's Lane, they spread out. The riders observed a school bus travelling toward them and Mr Avage and two other riders stopped approximately halfway down the hill, to allow the bus to pass safely through a narrowing in the road. After the bus passed, Mr Avage and two others at the front of the group began riding again, reaching an estimated 40km/h. Mr Avage was riding in the centre of the carriageway and just before the patch of mud appeared to swerve to the right, in an attempt to avoid the mud. Mr Avage lightly clipped the back wheel of the bike in front of him and fell heavily to the right.

8. Mr Avage's head hit the road surface and he slid for approximately 25 metres, coming to rest on the edge of the opposite side of the road. Group members, including a retired police officer, rendered first aid and phoned '000' for assistance. Mr Avage was unconscious from the time he fell.

9. Paramedics arrived approximately ten minutes after Mr Avage fell. The paramedics rendered assistance and requested MICA (Medical Intensive Care Ambulance) and Helimed units to attend. Mr Avage was transported by helicopter to the Alfred Hospital with life-threatening injuries.

10. Mr Avage was diagnosed to have suffered a large acute subdural haemorrhage on the left of his brain, with midline shift. Neurosurgeons deemed Mr Avage's injury non-survivable and surgery was not indicated. Palliative care was instituted and Mr Avage died on 4 September 2014, surrounded by his family.

11. Police were not called to attend the scene, as no other vehicles were involved in the incident and Mr Avage was alive at the time he was transported from the scene.

Post Mortem Examination

12. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem inspection and completed a report on 23 September 2015. Dr Burke formulated Mr Avage's cause of death was head injury. I accept Dr Burke's opinion.

Comments

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

13. Paramedics attending to Mr Avage did not request police attendance at the scene of the incident, reportedly because Mr Avage's injuries resulted from a fall where no other party or vehicle was involved in the incident and Mr Avage was alive at the time he was transported from the scene. However, at least one of the treating paramedics stated that he considered that Mr Avage had a "closed head injury and ... life-threatening injuries".

14. At approximately 4.50pm on 3 September 2014, Leading Senior Constable Tim Marshall of the Maffra Police Station received a telephone call from the Alfred Hospital, requesting he attempt to locate Mr Avage's family, which he did. Over the course of the next week, LSC Marshall made enquiries with the Emergency Services Telecommunications Authority (ESTA) and received communications from ESTA, the Alfred Hospital and other local police stations in relation to the circumstances of Mr Avage's death.

15. On 12 September 2014, LSC Marshall attended the scene of Mr Avage's fall, at Norden's Lane, Maffra. LSC Marshall inspected the area and took photographs which show water, mud and gravel over the area where Mr Avage fell. It had rained on 10 September 2014.

16. On 13 September 2015, LSC Marshall and Senior Constable Binotto of the Wellington Highway Patrol again attended the scene. They collected measurements from which LSC Marshall developed a Traffic Incident System report sketch.

17. LSC Marshall made enquiries regarding:

    a. the construction of 'crossovers' (the point at which the driveway meets the road) as to debris on the road; and

    b. the local regulations covering the construction of crossovers and requirements for removal of debris from the surface.

18. LSC Marshall stated that persons in charge of vehicles of livestock are required to remove any unreasonable amounts of substance that falls to the road surface. However, presumably regular users are not required to remove gravel that is dragged from the side of the road onto the road surface.

19. LSC Marshall informs me that Sergeant Banwell, Officer in Charge of Wellington Highway Patrol, conducted an audit in relation to the circumstances of Mr Avage's fall and his subsequent death. As part of the audit, Sergeant Banwell engaged both the Wellington Shire and VicRoads regarding strategies to prevent mud and debris from being tracked onto road surfaces.

20. The Wellington Shire Council advised as follows in relation to strategies to address the issue of debris being tracked onto roadways:

    "Under the current Road Management Plan, the defect of 'materials causing slippery or dangerous conditions' is given the highest priority for response, with a response time of 24 to 72 hours dependent on the classification of the particular road. Roads are proactively inspected for hazards at a frequency of between 3 months and 24 months, dependent on the classification of the road.
    In addition to the processes specified through the Road Management Plan, the movement of livestock between rural properties requires a permit. This activity has a high potential to concentrate debris on road surfaces. As a condition of this permit, the permit holder must maintain the roadway free from debris. Permitted sights are routinely and reactively inspected.
    (Wellington Shire Council) also conditions the construction of any works within the road reserve including property accesses to ensure all new works are constructed to an appropriate standard which minimises the potential for debris on road surfaces."

21. The Court has since made enquiries with Ambulance Victoria regarding their notifications to Victoria Police in circumstances where a patient has suffered possibly life-threatening injuries in a fall. Ambulance Victoria advised that their protocols do not require paramedics to notify police in the event of a fall where no other vehicle or mechanism is involved. However, as a result of this matter, Ambulance Victoria will be approaching Victoria Police and the Emergency Services Telecommunications Authority to review the circumstances of when police should be notified about such cases.

22. I note that police attendance at the scene on the day of the incident would not have altered the outcome for Mr Avage, nor has the investigation been so compromised by the delays in police attendance as to render me unable to make the findings I am required to make under the *Coroners Act 2008*. As such, I make no recommendation in relation to the facts and circumstances of this case.

Finding

I find that:

1. The identity of the deceased was Alfred Norman Avage; and
2. Mr Avage died on 4 September 2014 at the Alfred Hospital, Melbourne, from head injuries suffered in a fall from his bicycle on 3 September 2014 at Norden's Lane, Maffra.

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that this finding be published on the internet.

I convey my sincere condolences to Mr Avage's family and friends.

I direct that a copy of this finding be provided to the following:
Mrs Isobel Avage, Senior Next of Kin
LSC Tim Marshall, Coroner's Investigator, Victoria Police
Sgt Banwell, Wellington Highway Patrol
The Alfred Hospital
VicRoads
The Wellington Shire Council

Signature:

CAITLIN ENGLISH
CORONER
Date: 14 · 4 · 16