

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2013 001377

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, ROSEMARY CARLIN, Coroner having investigated the death of BRENDAN PAUL LYNCH without holding an inquest:

find that the identity of the deceased was BRENDAN PAUL LYNCH  
born on 30 March 1961

and the death occurred 31 March 2013

at the Northern Highway on-ramp to the Hume Freeway in Wallan, Victoria 3756

from:

1a. MULTIPLE INJURIES

**Pursuant to section 67(2) of the Coroners Act 2008, I make findings with respect to the following circumstances:**

1. Brendan Lynch was born on 30 March 1961 and was 52 years old at the time of his death. Mr Lynch lived in Benalla and is survived by his wife and four children. Mr Lynch was a Senior Constable of Police with the Benalla Highway Patrol.
2. A brief prepared by Victoria Police for the Coroner includes statements obtained from Mr Lynch's wife, witnesses and from investigating officers. I have drawn on all of this material as to the factual matters in this finding.
3. Mr Lynch was a keen cyclist who had ridden to Melbourne to celebrate his birthday every year for the 12 years preceding his death. Mrs Lynch was Mr Lynch's support person and she would drive about five kilometres ahead of him, stop, and wait for him to pass.
4. On 31 March 2013 at approximately 7 a.m., Mr Lynch started his ride from Benalla to Melbourne. Mr and Mrs Lynch travelled out of Benalla along the Baddaginnie road to

Baddaginnie, then the Hume Freeway to Euroa. They then stopped for 10-15 minutes where they consumed food and drinks. After this, they got back on the Hume Freeway and took the Longwood exit and the Avenel-Longwood Road to Seymour where they stopped for lunch.

5. Approximately 30-40 minutes later, Mr and Mrs Lynch continued back onto the Hume Freeway and travelled to Wallan. At around 1.30 p.m., they stopped at the Wallan Service Centre and after having a drink, they continued on their journey. Mrs Lynch drove past Mr Lynch as he was entering the Hume Freeway and she continued to Kalkallo, where she stopped on the side of the road to wait for him to pass.
6. Also around that time, a passenger bus with Victorian registration had just left Kilmore Railway Station. The bus was a V-line service replacing trains to Southern Cross Railway Station. The driver, Karin Folino, had completed a morning run from Southern Cross Railway Station to Seymour Railway Station and after leaving Kilmore East, she estimated the bus would have been carrying about 30 passengers.
7. At approximately 1.55 p.m., Mr Lynch was cycling in the emergency lane of the Hume Freeway and was nearing the point where the Northern Highway merged onto the Hume Freeway. At this time, Ms Folino was driving her passenger bus south along the Northern Highway, approaching the on-ramp to the Hume Freeway. As the bus commenced the merge onto the Hume Freeway, Mr Lynch turned his bicycle to the left and into the path of the bus, where he was struck. He was knocked from his bicycle and although attempts were made to resuscitate him by members of the public and paramedics, he was unresponsive and died at the scene.
8. Some witnesses observed that immediately prior to the collision Mr Lynch appeared to be struggling with a headwind. He was observed by bus passenger Reginald Newman to have looked over his left shoulder before putting his left arm out to signal that he was intending on merging into the lane. Other witnesses, including Ms Folino, also saw Mr Lynch extend his left arm to indicate he was about to move left, however they did not see him look over his shoulder for traffic.
9. Ms Folino took her foot off the accelerator as soon as she saw Mr Lynch. She believed that he would wait for the bus to pass before he turned into her lane, but he did not. As soon as he merged, she applied her brakes but it was too late and she hit him. The thrust of the

witness statements in the coronial brief was that there was nothing Ms Folino could have done to avoid Mr Lynch.

10. An inspection of Mr Lynch's body was undertaken by Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine. The examination revealed extensive external and internal injuries sustained in the incident. Toxicological analysis of post-mortem samples did not reveal any evidence of alcohol or common drugs and poisons being present in the blood at the time of the incident. Dr Burke reported the cause of death as 1(a) Multiple Injuries.

#### *Incident analysis*

11. Detective Sergeant Peter Bellion of the Major Collision Investigation Unit prepared an expert report for the Coroner following an investigation of the circumstances<sup>1</sup>. There were no skid marks observed from the bus. Mr Lynch did not appear to have been wearing any headphones at the time of the collision. The bus was travelling at an estimated speed of 82-90 km/h at impact.
12. Detective Sergeant Bellion noted that from a cyclist's point of view, one would be riding along the emergency lane on approach to the on-ramp and then would cross the on-ramp carefully near the end of the gore<sup>2</sup> area between the emergency lane and the on-ramp lane. Crossing at this point means the cyclist would spend the least amount of time actually in the path of the on-ramp traffic. The cyclist would normally be looking to his or her left riding adjacent to the on-ramp and then do a further left turn head check to ensure it was clear for him or her to cross the on-ramp lane.

#### *Signage and VicRoads submissions*

13. VicRoads have submitted that the traffic signs at the site of the collision were based on standards that were in place at the time of the original installation and that whilst these signs 'do not technically match the current guidelines, they carry substantially the same message to drivers and cyclists' and are considered adequate for the site.<sup>3</sup>

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<sup>1</sup> Dated 2 April 2013.

<sup>2</sup> Triangular area where the two roads meet.

<sup>3</sup> Letter from VicRoads dated 21 February 2014.

14. The sign located on the Northern Highway ramp approaching the freeway merge that related to bicycles on the main freeway carriageway is a diagrammatic bicycle warning sign with a supplementary panel "CROSSING 150m". The sign is to warn motorists on the ramp that bicycles may be crossing the ramp 150m ahead. Also, the freeway approach to the ramp has a diagrammatic merging traffic sign.
15. Current standards require the installation of a sign on the freeway approach to an entry ramp showing a bicycle symbol with words "cross here with care". VicRoads have confirmed that this sign or a similar sign was not present at the site at the time of the collision.
16. VicRoads indicated that under rule 74 of the Road Safety Rules 2009, Mr Lynch was required to give way to the bus, however this rule is generic in nature and it is not immediately apparent that it governs the situation of cyclists on freeways merging with on-ramps<sup>4</sup>.
17. VicRoads also submitted that the function of a 'cross here with care' sign is not to indicate which road user should give way to the other user and that it is not a regulatory sign. The sign is classified as a traffic instruction sign, used to advise cyclists where they are expected to cross a ramp to a freeway shoulder.
18. The VicRoads website contains information about bicycle safety including tips for cycling on rural freeways. The website states riders should 'Cross freeway ramps at right angles. Don't cross diagonally.'

### *Conclusion*

19. I am satisfied having considered all the evidence before me that no further investigation is required. I am satisfied that Mr Lynch failed to give way to the bus travelling on the on-ramp and that there was nothing the driver of the bus could reasonably have done to avoid the collision.
20. I find that Brendan Lynch died on 31 March 2013 from multiple injuries sustained in a motor vehicle incident in which he was a cyclist.

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<sup>4</sup> The Rule is headed 'Giving way when entering a road from a road related area or adjacent land'.

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

1. Whilst road users, including cyclists, have an obligation to understand road rules, this does not mean that they always do, or that they obey them. Regulatory signs should exist to clarify the obligations of competing road users in inherently dangerous or confusing situations or where there is an increased risk that road rules, even if known, will not be obeyed.
2. Bicycle riding on a freeway is an inherently dangerous situation and the danger increases dramatically at intersections with on-ramps. Although Mr Lynch's overall direction was straight ahead, it was necessary for him to cross the ramp to achieve this. Further, although his direction was straight ahead, he was obliged to give way to the merging traffic, not vice versa. Mr Lynch was a police officer and an experienced cyclist who had previously cycled on freeways towards Melbourne. It would be surprising if he did not know the applicable Road Safety Rule and yet there is some evidence that he was behaving as if he expected merging traffic to give way to him<sup>5</sup>. Either way, effective signage at the location of the site may have prevented him from crossing the ramp in the manner that he did.
3. It must also be remembered that cyclists suffer from fatigue and that may affect their actions and decision making. There is some suggestion in the witness statements that Mr Lynch was struggling against a headwind and appeared fatigued. Clear signage, which reinforced his obligation to give way, may have ensured his compliance.

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<sup>5</sup> By extending his left arm and then merging across the on-ramp without appearing to check for traffic.

## RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. If they have not already done so, that VicRoads erect a 'cross here with care' sign on the Hume Freeway nearing the point of the Northern Highway merge to indicate to cyclists that they should cross at this particular location.
2. That all freeway bicycle 'cross here with care' signs should be accompanied by a panel or additional sign to indicate that the cyclist must give way to merging traffic. It should also be made clear either by signage, road markings or both, that the cyclist should cross the on-ramp at a right angle at a particular point.
3. That VicRoads consider conducting a bicycle safety campaign targeted at rural road users with particular focus on cycling on freeways, the manner of cyclists merging and the proper interaction between cyclists and other road users.

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

The family of Mr Brendan Lynch;

Investigating Member, Victoria Police;

The Honourable Terry Mulder, Minister for Public Transport and Roads;

VicRoads;

Transport Accident Commission; and

The Interested Parties

Signature:



ROSEMARY CARLIN

CORONER

Date: 2 July 2014

