

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2012 1909

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

Amended pursuant to section 76 of the *Coroners Act 2008* on 16 February 2015

I, JOHN OLLE, Coroner having investigated the death of DIANNE WILLMA MACINTYRE without holding an inquest:

find that the identity of the deceased was DIANNE WILLMA MACINTYRE

born on 6 August 1993

and the death occurred on 26 May 2012

at The Alfred Hospital, 55 Commercial Rd, Melbourne VIC 3004

from:

1(a) INJURIES SUSTAINED IN MOTOR VEHICLE COLLISION (PASSENGER)

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

1. Dianne Macintyre was born on 6 August 1993 and was 18 years of age at the time of her death. She is survived by her parents, William and Deborah Macintyre, with whom she maintained close and loving relationships.
2. A coronial brief was provided by Victoria Police to this Court, including statements obtained from witnesses, treating clinicians and investigating officers. I have drawn on all of this material as to the factual matters in this finding.

BACKGROUND AND CIRCUMSTANCES

3. On 26 May 2012 at approximately 10.40am Mitchell Lander was driving a maroon 1995 Subaru Liberty Station Wagon, registration RFW669, travelling south bound along Coolart

Road, Tyabb, with Dianne, who was sitting in the front passenger seat. At the time of the accident Mr Lander held a probationary (P1) Victorian Motor Vehicle Licence.¹ Mr Lander described the road as wet, although not raining at the time of the accident, the traffic as medium and the weather as clear with no direct sun glare. He crossed through the roundabout at Bungower and continued south towards the roundabout at Mornington-Tyabb Road. He then recalled hitting a pothole on the passenger side further down the road and losing control of the car.²

4. At that time Scot Benstead was driving a silver 2010 Hyundai SLX hatchback, registration XRY314, travelling north bound along Coolart Road, when he observed Mr Lander's vehicle cross into the north bound lane with the passenger side of the vehicle facing him. Mr Benstead applied his brakes heavily, however made contact with Mr Lander's vehicle.³ Mr Benstead's vehicle came to rest on the side of the road in a south west direction, and Mr Lander's vehicle came to rest on the side of the road in a north westerly direction.⁴
5. Police and ambulance services attended shortly after the accident. Mr Lander and Mr Benstead both received minor non-life threatening injuries. Dianne had 15 minutes of pulseless electrical activity arrest and received spontaneous circulation while being airlifted to The Alfred Hospital. Upon admission she had a Glasgow Coma Score of 3 and received ongoing resuscitation in the Emergency Department. She had ongoing haemodynamic instability and received a CT scan en route to theatre for a laparotomy, pelvic packing and fixation. At laparotomy extensive free blood⁵ was present with the likely source coming from the retroperitoneum and pelvis. Dianne arrested twice intra-operation and treatment was withdrawn in theatre once the extent of brain trauma was identified. Sadly, Dianne passed away at 1.50pm that afternoon.⁶

¹ Vicroads section 84(1) certificate, Coronial brief, Exhibit 3.

² Statement of Mitchell Lander, dated 30 May 2012, Coronial brief.

³ Statement of Scot Benstead, dated 30 May 2012, Coronial brief.

⁴ Statement of L/S/C Lee Marriott, dated 5 October 2012, Coronial brief.

⁵ Greater than 2 litres.

⁶ E-medical deposition, dated 26 May 2012, Court reference 1909/12.

INVESTIGATION AND COLLISION ANALYSIS

6. Just prior to Mr Lander's vehicle crossing into the north bound lane, Mr Benstead recalled observing a long puddle along the side of the road in the south bound lane.⁷ A number of witnesses to the accident stated that Mr Lander did not appear to be speeding at the time of the accident,⁸ and there is no evidence to the contrary. A number of witnesses observed Mr Lander's vehicle travelling south towards them before suddenly, for an unknown reason, veering out of control and fishtailing before swerving into oncoming traffic and colliding with Mr Benstead's car.⁹ Mr Lander was not sleep deprived at the time that he drove, receiving approximately nine hours sleep the night prior.¹⁰
7. Police reported the point of impact was on the west shoulder of Coolart Road, approximately 0.5 metres from the line dividing the shoulder and north bound lane. This part of Coolart Road is a single sealed carriageway length of road, with provision for one north and south bound lane. It is approximately 6 metres wide. It has small 1.2metre sealed shoulders which run into grass ditches or drains and has a 90km/h speed limit.¹¹
8. The road conditions on the morning of the collision were very wet. It had rained quite heavily and consistently over the previous 24 hours and there was a lot of water on the roads. At the location where the collision occurred, the road was in a very poor condition due to the rain. Water had formed in the south bound lane in the left hand wheel tracks. Earlier the water had been so deep that the pot holes were not visible underneath. There was no evidence of impact with the pothole due to the roads being wet and in poor condition. There were no skid marks or visible damage to Mr Lander's vehicle as a result of hitting the pot holes. There were no other reported incidents or earlier calls regarding the pot holes.¹²
9. Mr Lander's vehicle had major damage to the passenger side. Measurements indicated that the deepest intrusion into the front passenger door was 80cm at the bottom of the door and 44cm at the top. Evidence suggests that all persons involved in the collision appeared to be

⁷ Statement of Scot Benstead, above n 3, Coronial brief.

⁸ Statement of Scot Benstead, 2; Statement of Connie Endicott, 2;

⁹ Statement of L/S/C Lee Marriott, above n 4.

¹⁰ Statement of Mitchell Lander, above n 2.

¹¹ Statement of L/S/C Lee Marriott, above n 4.

¹² Ibid.

wearing seat belts. Constable Quinn performed a preliminary breath test on Mr Lander, which returned a negative result.¹³ A subsequent blood test was taken from Mr Lander and ethanol, drugs and poisons were not detected.¹⁴ Police confirmed that Mr Lander's vehicle service history supports that the mechanical condition of Mr Lander's car was not a factor.

10. Police advised that it appears that the poor condition of the road with pot holes and water, due to recent heavy rains, were the contributing factor to the cause of the collision.¹⁵ Speed was not a factor.
11. Vicroads provided two statements and a report in relation to this investigation. I will now refer to relevant aspects of these documents. Coolart Road is classified as a 'category 3' road and is inspected weekly. Records show that Coolart Road was inspected on 3, 10, 17, 24 and 31 May 2012.¹⁶ The road was in poor condition from heavy rain in the previous 24 hours. There was heavy rain the previous day which caused flooding in various parts of Victoria, including the Mornington Peninsula. VicRoads Surveillance Officer Alan Willie advised on 29 May 2012 that on the day of the collision there were two pot holes approximately 60mm deep x 1.0m long x 0.5m wide at the site of the collision. The pothole suspected of being stuck was located within a line of rutting/smooth surface running near and parallel to the edge line. He also noted other pot holes of various sizes present on that section of road. Mr Willie advised that the intervention level for pot holes is 100mm depth.¹⁷
12. The grassed roadside verge on the east side of Coolart Road in the vicinity of the collision site is, in places, higher than the adjacent sealed shoulder, restricting drainage from the road and causing localised pooling/ponding of water. On 3 May 2012 ETS 500441922 was logged regarding drainage issues on Coolart Road between Bungower and Mornington-Tyabb Road. ETS 500449334 was logged on 25 May 2012, one day prior to the collision, regarding water over the road on Coolart Road near Graydens Road. Verge regrading works between Bungower Road and Mornington-Tyabb Road had been identified prior to the

¹³ Statement of L/S/C Lee Marriott, above n 4.

¹⁴ Victorian Institute of Forensic Medicine Toxicology Certificate for Mr Mitchell Lander, taken 26 May 2012.

¹⁵ Statement of L/S/C Lee Marriott, above n 4.

¹⁶ Statement of Adam Maguire, dated 9 January 2014.

¹⁷ Vicroads Accident Report AR5484.

fatality and programmed to be undertaken in the future. Of note, these works were subsequently completed on 30 May 2012, to assist drainage flows from the roadway.¹⁸

13. Police arranged for immediate temporary patching of the pot holes claimed to have been struck by Mr Lander's vehicle prior to the crash. Subsequent permanent patching of these and other holes between Bungower Road and Morning-Tyabb Road was undertaken on 28 and 29 May 2012.
14. The speed limit of 90km/h was reviewed as part of the recent submission to the Minister and was considered appropriate to be retained.¹⁹

INSPECTION AND REPORT

15. A post-mortem inspection and report was undertaken by Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lynch reported that external examination findings are consistent with the history.
16. The post-mortem CT scan reveals haemoperitoneum, bilateral haemothoraces, blood at the base of the brain, fractures of the left ilium and of the left and right inferior and superior public rami.
17. Dr Lynch reported that the cause of death is injuries sustained in a motor vehicle collision (passenger).

RECOMMENDATIONS

18. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with the death:
 - a) That Vicroads review their policy regarding the intervention level for pot holes, so that it be reduced from 100mm depth to approximately 50mm.

FINDING

19. I am satisfied, having considered all of the available evidence, that there are no suspicious circumstances surrounding Dianne's death and that no further investigation is required

¹⁸ Ibid; Works on the east side of Coolart Road, between Oxford and Cambridge Street.

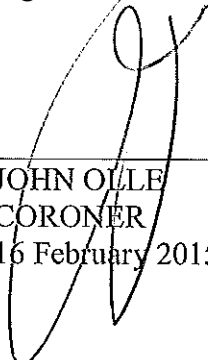
¹⁹ Vicroads Accident Report AR5484.

20. I find there is no evidence to suggest that illness or mechanical fault contributed to the collision.
21. The evidence satisfies me that the medical management and care provided by The Alfred Hospital was reasonable and appropriate in the circumstances, having regard to the complexities involved. The evidence does not support a conclusion that the medical care or management caused or contributed to Dianne's decline or death.
22. I find that Dianne Macintyre died on 26 May 2012 and that the cause of her death is injuries sustained in a motor vehicle collision (passenger), in circumstances where the road was in very poor condition with water pooling and pot holes, due to heavy rain in the days prior to the collision.

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

The family of Dianne Macintyre;
Interested parties; and
Investigating Member, Victoria Police

Signature:



JOHN OLLE
CORONER
16 February 2015

