IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5350

FINDING INTO DEATH WITHOUT INQUEST

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

I, PHILLIP BYRNE, Coroner having investigated the death of JOHN PACE

without holding an inquest:
find that the identity of the deceased was JOHN PACE
born on 2 November 1934
and the death occurred on 22 November 2013
at the intersection of Mt Cottrell Road and the Western Freeway, Melton

from:

1 (a) HEAD AND CHEST INJURIES SUSTAINED IN A MOTOR VEHILCE COLLISION (DRIVER)

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

1. Mr John Pace, 79 years of age at the time of his death, resided at 768 Greigs Road, Rockbank, Victoria 3335 with his wife Mrs Margaret Pace.
2. Mr Pace had a medical history that included ischaemic heart disease, hyperlipidemia, asthma, anxiety, hearing loss and cataracts.
3. On 22 November 2013 Mr and Mrs Pace had dinner with Mr Pace's brother, Mr Fred Pace, at his Highett Road, Melton address. According to Mr Fred Pace they left after dinner at around 10pm in their maroon Toyota Camry. Mr Fred Pace also states that Mr John Pace, who was driving, only had one light stubby all night.
4. Mr Fred Pace also remembers that Mr John Pace turned on his headlights as he was leaving the property as it lit up a rabbit on the driveway. He also said that when they

were leaving Mr John Pace said that they would cross the Western Freeway at Mt Cottrell Road, and that the crossing should be quiet at that time of night.

5. Driving conditions that night were relatively good. Although it was dark at that time and the Mt Cottrell Road/Western Freeway was not lit, the weather was fine, visibility was clear and the road surface was dry.

6. Mr John Burr was heading east along the Western Freeway towards Melbourne in a Lexus 4WD wagon. He was accompanied by two passengers, Mr Vincent Lee and Mr Marco Matic. As they approached the Mt Cottrell Road crossover Mr Pace's vehicle pulled out from the north side of the Highway heading towards the south side. Mr Burr's vehicle collided with Mr Pace's vehicle with the impact occurring on the drivers side door of Mr Pace's vehicle. Mr Pace's car was pushed approximately 50m along the freeway as a result of the collision.

7. Mr Burr in his statement to the court describes the red car driving out in front of his vehicle when he was about 5 metres away from the crossover. He stated that he had no time to brake or take evasive action. He describes how the front of his car hit the drivers door area of the red car and how it was a really hard impact.

8. Both vehicles came to a stop against the roadside barriers. The three occupants in the Lexus had relatively minor injuries and we able to exit their vehicle. They checked on Mr and Mrs Pace and both appeared to be deceased. Mr Vincent Lee called ambulance paramedics who attended and formally pronounced both Mr and Mrs Pace deceased.

9. As the death was unexpected the matter was referred to the Coroner. Upon coronial direction an external only post mortem examination was carried out at the Victorian Institute of Forensic Medicine by Senior Forensic Pathologist Dr Noel Woodford. Dr Woodford found that cause of death was head and chest injuries sustained in a motor vehicle collision (driver).

10. As part of the Victoria Police investigation into this incident Senior Constable Nick Brickley of the Mechanical Inspection Unit inspected both vehicles. He noted that Mr and Mrs Pace's Toyota Camry would have been classed as being in an unsafe condition prior to the impact due insufficient tyre tread depth on three of the four tyres. However he noted that this fact would not have any bearing on the collision. His inspection did not reveal any mechanical fault with the vehicle that would have caused or contributed to the collision.

11. Senior Constable Brickley's inspection of the Lexus 4WD wagon found that the vehicle would have been classed as being in a safe mechanical condition prior to the collision.

12. I formally find that Mr John Pace died as a result of injuries received in a motor vehicle collision.

COMMENTS

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

13. The Coronial Investigator, Leading Senior Constable Craig Kelso of the Melton Highway patrol, provided the Court with very comprehensive Briefs of Evidence in relation to the deaths of Mr and Mrs Pace. I commend his thoroughness. Importantly, in what is titled a Briefing Note, Leading Senior Constable Kelso makes strong recommendations concerning several median strip "crossover points" at:

    - Troups Road North
    - The Sundowner Caravan Park
    - The Rockband Garden Centre (Nursery)
    - Paynes Road
    - Mount Cottrell Road

14. The "crossover points" allow traffic from those side roads wishing to travel in an easterly direction (towards Melbourne) to cross the west bound carriageway of the highway towards Ballarat, or intending to travel in a westerly direction (towards Ballarat) to cross the east bound carriageway of the highway towards Melbourne.

15. Leading Senior Constable Kelso urges me to recommend those crossovers be "barricaded off"; closed to traffic so that drivers wishing to travel in either direction would be required to utilise the major exchanges" located at Robinsons Road, Christies Road, Hopkins Road, Leakes Road, Ferris Road and Coburns Road.

16. The same issue was referred to Coroners Prevention Unit[1] by my colleague Coroner Jamieson in an unrelated matter. Investigations undertaken by that unit sought input by

[1] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner in formulating prevention recommendations and in monitoring and evaluating the effectiveness of recommendations once published.

VicRoads as to the feasibility and appropriateness of closing off those median strip "crossover points".

17. Mr Francis To, Office Manager of VicRoads Legal Services, advised that during the period of 1 January 2013 to 31 December 2013 there have been 191 reported crashes on the Western highway between Robinsons Road Ravenhall and Djerriwarrh Creek, including four fatalities. He further advised that a "high level study" was undertaken. It would appear that the recommendations proposed by Leading Senior Contable Kelso accord with recommendations of the Western Freeway Rockbank to Melton, Access Restorations Project Strategy which were, I am advised, adopted and endorsed by VicRoads. To date that project has not been funded.

18. I support those recommendations relating to the "crossovers" be adopted.

RECOMMENDATIONS

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

I acknowledge the helpful input by the Coroners Prevention Unit.

19. I recommend that earnest consideration be given to the closing of the median "strip crossovers" on the Western highway at:

- Troups Road North
- The Sundowner Caravan Park
- The Rockband Garden Centre (Nursery)
- Paynes Road
- Mount Cottrell Road

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

Ms Joanne Pace

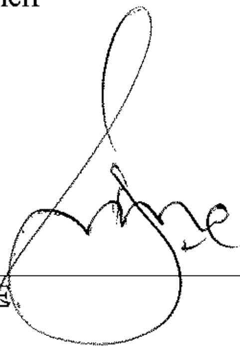
Leading Senior Constable Kelso, Melton Highway Patrol

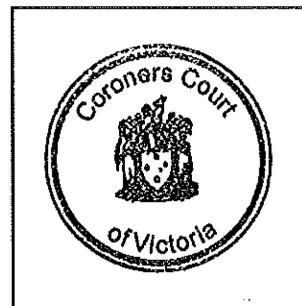
VicRoads

The Secretary of Transport, Planning & Local Infrastructure

Melton City Council

Signature:





PHILLIP BYRNE
CORONER
Date: **29 October 2014**