IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 004387

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 THEODORE ATSAVES without holding an inquest:
find that the identity of the deceased was THEODORE ATSAVES
born on 30 April 1935
and the death occurred on 21 November 2011
at Yarra River, Yarra Boulevard, Kew, Victoria
from:

1(a) DROWNING

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. Mr Theodore Atsaves was born on 30 April 1935 and was 76 years old at the time of his death. Mr Atsaves lived in Brunswick with his wife, Georgina. He is survived by his wife, children and grandchildren. He was retired.

2. A brief prepared by Victoria Police for the Coroner includes statements obtained from Mr Atsaves' wife, his treating clinician, witnesses and investigating police officers. I have also considered correspondence received throughout the investigation from Mr Atsaves' family including statements from an expert. I have drawn on all of this material as to the factual matters in this finding.

3. Mr Atsaves was born in Greece and migrated to Australia followed by his wife in the 1960s. He never learned to swim.

4. Mr Atsaves had a medical history including skin cancer (removed), moderately raised blood pressure, history of excessive alcohol intake (reportedly reduced in recent times) and elevated fasting blood glucose and abnormal liver function tests.[1] He was otherwise considered to be in good health and was observed by his family as being active, sleeping well and as having no ongoing medical concerns.[2]

5. Mr Atsaves loved driving and took pride in his car, which he kept in excellent condition. It was serviced regularly and repaired whenever necessary.3 The last repairs were carried out on 20 October 2011 to the engine cooling system. Mr Atsaves held a full and current Victorian drivers licence and did not have a history of recorded traffic offences.

THE INCIDENT

6. On Monday 21 November 2011, Mr Atsaves woke at his usual time, around 8 a.m., and spent some time doing tasks at home. At approximately 10 a.m., Mr Atsaves fed his grandson, John, whom he was looking after that morning. He was in good spirits and told his wife he was going to take John to kindergarten and then travel to Northcote to buy supplies for a party they were hosting that night. He left shortly after, driving his 1999 Holden Commodore Berlina sedan.

7. At approximately 2 p.m., Mr Atsaves' car was observed travelling along Yarra Boulevard, Kew in the direction from Chandler Highway towards Studley Park Road. It is unknown why Mr Atsaves was at that location. The posted speed limit was 50 km/h.

8. Several witnesses noticed that his car was making a loud, unusual noise and emitting an unusual smell. The noise was variously described by witnesses as "metallic", as though "it was held in gear", "like an exhaust pipe dragging on the road", "something mechanical like a fan belt [a] knocking sound" and "like a bang bang bang sound". One witness stated the rear bumper appeared to be dislodged.

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[1] Statement of Dr Jeffrey Erlich dated 19 December 2011, page 1.

[2] Statement of Georgina Atsaves dated 24 January 2012, page 2.

[3] Statement of Wayne Martin dated 21 December 2011, page 1.

9. Witnesses observed Mr Atsaves' car to be out of control, weaving from his lane to the opposite lane. He appeared to be trying to stop or gain control of his car however, it then spun onto the opposite side of the road and travelled backwards through a wire fencing barrier over the edge of a steep embankment into the Yarra river. As the car was travelling backwards one witness claimed to see the car's reversing lights and another thought that he did.

10. The drop from the footpath to the water was approximately 30 metres with a 45 degree descent.[4] The car floated for approximately 60 metres downstream before sinking. Mr Atsaves remained in the vehicle the whole time.

11. Emergency services were called and arrived at the scene shortly after. They were directed to the approximate area the car was last seen. A member of the search and rescue squad, Leading Senior Constable (LSC) Dehnert, located the car at approximately 3.35 p.m submerged in 6.2 metres of water. Mr Atsaves was deceased inside the vehicle.

12. Inspection of the car upon its retrieval from the water revealed that it had very little damage. The keys were in the ignition, the handbrake was in the off position and the transmission selector lever was in third gear position.

POST MORTEM FINDINGS

13. An autopsy was undertaken by Dr Matthew Lynch, Senior Forensic Pathologist with the Victorian Institute of Forensic Medicine. At autopsy there was evidence of emphysema aquosum, a common sign in cases of drowning. Significant natural disease was noted in the form of cardiomegaly, possibly the result of a history of high blood pressure. Also noted were microscopic changes in the brain suggestive of Parkinson's disease. Dr Lynch reported the cause of death as 1(a) Drowning.

INVESTIGATION OF THE VEHICLE AND COLLISION

14. Members of the Major Collision Investigation Unit (MCIU) attended the scene on the day of the collision. Detective Senior Constable (DSC) Hay[5] examined the scuff marks and noted "[t]he motion of the vehicle was consistent with the rear brakes suddenly being applied and a

[4] Statement of Detective Leading Senior Constable Tony Gentile dated 12 February 2012, page 1.

[5] DSC Hay has an Honours degree in civil engineering and various other qualifications relevant to accident reconstruction.

large steering input to the right. Once the vehicle has spun 180° the steering has straightened and the Holden has skidded straight through the pedestrian fence and down the river bank". He estimated that the car was travelling at a minimum speed of 51 km/h at the beginning of the skid.

15. DSC Hay concluded that he could not say why the collision occurred, only that the rear wheels became locked and a steering import was applied, causing the car to rotate rapidly in a clockwise direction then straighten and skid backwards through the pedestrian barrier and down the river bank.

16. Mr Atsaves' car was inspected by Leading Senior Constable (LSC) David Ackland of the Mechanical Investigation Unit (MIU), Victoria Police on 15 December 2011. The car had ABS brakes fitted. His inspection did not reveal any mechanical fault that would have caused or contributed to the collision and he concluded it would have been classed as mechanically safe prior to the collision

17. Subsequently, consultant engineer Andrew Enkelman of Enkelman Technologies Pty Ltd, inspected Mr Atsaves' vehicle on behalf of Mr Atsaves' family. This occurred on 19 January 2012.

18. Mr Enkelman provided three reports following his inspection of Mr Atsaves' car. In his first report dated 16 February 2012, he noted that his inspection of the vehicle's accelerator revealed scraping noises within the throttle body. He could not determine whether this was caused by the ingress of contaminated water into the throttle body or was present at the time of the incident and concluded that he was unable to provide 'a cause or contributory cause' for the incident.

19. LSC Ackland then provided a more detailed report in which he indicated that when he inspected the vehicle the accelerator operation was smooth and the handbrake was serviceable.

20. In his second report dated 13 November 2013 Mr Enkelman explored why the rear wheels of Mr Atsaves' car might have locked. He concluded that Mr Atsaves' car was involved in "an uncontrolled skid caused by the failure of its transmission, probably in the area of the planetary gear assembly which is normally associated with loud mechanical noises and may result in the lock up of wheels". In his final report dated 27 November 2013, Mr Enkelman suggested that further investigation into the rear axle and transmission of Mr Atsaves' car

"would probably have established whether one or the other of these components was the principal cause" of the collision.

21. Sergeant Leigh Booth of the MIU considered all of Mr Enkelman's reports, the reports of other members of the MIU and witness statements and provided his expert opinion in a report dated 28 October 2014. Sergeant Booth reviewed Mr Enkelman's assertion that a probable failure of the engine cooling system caused failure and lock-up of the transmission. He consulted specialists in the field of automatic transmissions and noted that although the comments varied amongst the experts, the general consensus (with the exception of one expert) was that complete transmission lock-up would not, or was very unlikely to, occur.[6]

22. Sergeant Booth agreed with Mr Enkelman that the fact the tyre scruff marks at the scene were from the car's rear wheels was consistent with either the vehicle's transmission or rear axle assembly locking. However, he was of the view rear axle lock up was more likely than transmission lock up. In any event, he noted that either failure would not have been immediate. Rather, it would have taken days, if not weeks during which time the car would have made considerable noise and the noise would have become progressively louder as the defect worsened.

23. As there is no evidence that anyone noticed any noise or defect prior to 21 November 2011, the possibility of driver error also cannot be excluded. It is possible the car's rear wheels locked up after the application of the handbrake, which was subsequently released.

24. In all the circumstances, I am not able to determine the cause of Mr Atsave's loss of control of the car.

FINDINGS

25. I am satisfied that no further investigation is required. I am satisfied that Mr Atsaves' death was accidental.

26. I find that Mr Theodore Atsaves died on 21 November 2011 as a result of drowning following the submerging of his vehicle in the Yarra River.

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[6] Statement of Leigh Booth dated 28 October 2014, page 7.

COMMENTS

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

1. The cause of Mr Atsaves' car losing control has been the focus of this investigation. Unfortunately, the car's transmission was never examined and the car was disposed of before this could be done.

2. In a letter dated 6 September 2013, Mrs Atsaves' raised a concern as to the adequacy of the wire fencing at the scene of the collision and submitted that a "safer road barrier" should be installed instead.

3. In an earlier report to the court dated 10 December 2012, VicRoads explained the structure of the road along this stretch including the 'clearzone' and purpose of wire fencing, which was to protect pedestrians from errant vehicles. Safety barriers were not required at the point that Mr Atsaves departed the road, as the embankment was 8.4m from the centre of his correct lane.

4. Enquiries with VicRoads and MCIU revealed no other incidents at that location where vehicles had entered the Yarra river. MCIU advised that although generally there are enough natural and other barriers to stop an out of control vehicle entering the Yarra river along Yarra Boulevard, there are certain areas where this is not so. The Pedestrian mesh fence in those areas is not sufficient to stop a vehicle.

5. Notwithstanding any legal requirements for safety barriers, it would be desirable for VicRoads to review the whole stretch of road along Yarra Boulevard with a view to installing vehicle barriers at those points not sufficiently protected by infrastructure, vegetation or other means to prevent a vehicle entering the Yarra river.

RECOMMENDATIONS

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

1. VicRoads should review the whole stretch of road along Yarra Boulevard and consider installing vehicle barriers at those points where it is possible that a vehicle that has left the road might enter the Yarra river.

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

The family of Mr Theodore Atsaves;

Investigating Member, Victoria Police; and

Vicroads;

Interested parties.

Signature:

ROSEMARY CARLIN
CORONER
2 February 2015