IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2013 5543

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of VALERIE BERYL MCNEIL

without holding an inquest:
find that the identity of the deceased was Valerie Beryl McNeil
born 19 July 1936
and the death occurred on 3 December 2013
at Warrnambool Base Hospital, Ryot Street, Warrnambool, 3280

from:

1 (a) MULTIPLE INJURIES (MOTOR VEHICLE IMPACT – DRIVER)

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. Mrs Valerie Beryl McNeil was 77 years of age at the time of her death. She lived in Warrnambool where she was actively involved in her community, having assumed numerous voluntary positions. Her medical history included spinal fusion.

2. At approximately 3.34pm on Tuesday, 3 December 2013, Mrs McNeil was driving her car, a 2009 Honda sedan, east along Wollaston Road, Warrnambool, behind an empty school bus. Her friend, Ms Evelyn Bartlett, was the front seat passenger. Whilst at the intersection of

Wollaston Road and Mortlake Road,[1] Mrs McNeil was braked, patiently waiting behind the school bus to turn onto Mortlake Road. After the bus turned left, Mrs McNeil's car crossed the give way line with a view to turning right to travel south along Mortlake Road. It is unknown whether Mrs McNeil has stopped at the give way sign and line prior to commencing her turn.

3. Ms Tessa Clark was driving her 2013 Nissan Dualis north along Mortlake Road, approaching the intersection of Wollaston Road.

4. Mrs McNeil turned right into Mortlake Road, directly in the path of Ms Clark's vehicle. Ms Clark later stated that she did not see Mrs McNeil's vehicle until it was directly in front of her. Ms Clark stated that she was travelling the signposted speed limit of 70kph and was unable to avoid a collision.

5. Ms Clark's vehicle impacted Mrs McNeil's vehicle's driver's door, causing major damage to both vehicles. Airbags in both vehicles deployed. Ms Bartlett sustained serious injuries requiring admission into the Intensive Care Unit. Ms Bartlett has since recovered.

6. Mrs McNeil was trapped in her vehicle for a considerable time before Emergency Services were able to extricate her. Emergency Services tried to arrange for the Air Ambulance to transport her to Melbourne, however the weather in Melbourne would not permit the Air Ambulance to land, and Mrs McNeil was instead transported to the Warrnambool Base Hospital.

7. Mrs McNeil's clinical condition deteriorated after her arrival, and she was pronounced deceased at 5.17pm, 3 December 2013.

INVESTIGATIONS

Forensic Pathology

8. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a post mortem examination on the body of Mrs McNeil, reviewed a post mortem CT scan and had available to him the Victoria Police Report of Death Form No. 83. Anatomical findings were consistent with the known mechanism of injury. No significant naturally occurring disease was identified.

---

[1] Also known as Hopkins Highway.

9. Toxicological examination of post mortem blood identified the presence of carbamazepine (used for the treatment of epilepsy, some forms of pain and Schizophrenia) and metoclopramide (an anti-nausea medication). Dr Dodd noted that on the advice of the toxicology department, the levels of medication detected do not exceed normal therapeutic usage. No alcohol was detected.

10. Dr Dodd ascribed the cause of Mrs McNeil's death to multiple injuries (motor vehicle impact – driver).

Police Investigation

11. The circumstances of Mrs McNeil's death have been the subject of investigation by Victoria Police. Police obtained statements from Ms Bartlett, Ms Clark, the bus driver and other witnesses.

12. The intersection of Mortlake and Wollaston Roads is a complex T-intersection, with Wollaston Road running east-west, being the terminating road controlled by a give way sign and give way line.

13. Sundale Road also runs east-west and is located opposite Wollaston Road, slightly offset approximately 20 metres to the south.

14. Wollaston Road has a signposted speed limit of 60kph and has a single marked lane of traffic in each direction with a raised concrete splitter island at the intersection.

15. Mortlake Road runs in a north-south direction and has numerous marked lanes including a dedicated left turn lane for traffic heading north as well as a centre turning lane for traffic heading both north and south to turn into Wollaston and Sundale Roads. Mortlake Road rises to the north with a blind crest approximately 300 metres away.

16. The intersection is visually very open, with no visual obstructions in the way of a vehicle travelling north along Mortlake Road.

17. Coroner's Investigator Senior Constable (S/C) Andrew MacMillan noted that a casual inspection of the intersection would not immediately show this intersection being of poor design, however he considered that it requires a redesign, as the distance required to be driven when stationary at Wollaston Road to travel south down Mortlake Road is considerable,

particularly if you are trying to enter traffic that is coming down a hill, from a blind crest at 70kph.

18. S/C MacMillan opined that the design of the intersection had some influence on the collision. S/C MacMillan said that a driver leaving Wollaston Road to turn right/travel south must travel over three running lanes, a distance of approximately 13 metres, to enter the south-bound running lane. The time taken to execute this manoeuvre would be approximately two to three seconds, during which time traffic coming over the crest on Mortlake Road would have travelled up to 60 metres from the crest, which is located 300 metres away, leaving little room for error.

19. Mechanical inspection of both vehicles conducted by the Victoria Police Mechanical Investigation Unit found both to be in mechanically safe condition and no mechanical faults were identified that could have caused or contributed to the collision.

20. Witnesses did not observe Mrs McNeil to be speeding or driving erratically prior to the collision.

21. The weather at the time was fine and dry with good visibility.

22. Ms Clark returned a negative preliminary breath test. She was the holder of a P2 Victorian probationary licence at the time of the collision. She has no criminal history and two recorded minor traffic infringements, being two speeding tickets in 2012 and 2013 (<10kph). She does not wear prescription glasses and was wearing sunglasses at the time of the collision.

23. Ms Clark admitted to sending text messages whilst driving, immediately prior to the collision, approximately 800 metres before the relevant intersection. Analysis of her telephone records does not show this text message, however photographs of her mobile telephone screen show text messages she had received at 3.33pm.

24. There is no evidence that Ms Clark was actually using her mobile telephone at the time of the collision. No charges were laid against Ms Clark in relation to this incident.

Further investigations

25. Contact was made with Mr Francis To at VicRoads to obtain road crash information regarding the relevant intersections on my behalf.

26. On 18 August 2014, Mr To provided the Coroner's Solicitor with a five year road crash history report (the report). The report indicated that there had been three other collisions around these intersections, two resulting in serious injury.

RECOMMENDATIONS

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

In light of Coroner's Investigator Senior Constable Andrew MacMillan's opinion regarding the apparent risks associated with the intersections, due to design, traffic flow, and inherent visibility constraints (as highlighted in paragraphs 17 and 18 above), together with the VicRoads' road crash history, and in light of Mrs McNeil's death, I **recommend** that VicRoads review the intersections of Hopkins Highway, Wollaston Road and Sundale Road, Warrnambool, with a view to upgrading the intersections with the aim of improving safety measures and preventing further serious injury and like deaths.

COMMENTS

Pursuant to section 67(2) of the **Coroners Act 2008**, I make the following comments connected with the death:

The evidence supports a finding that Mrs McNeil failed to pay due attention to the give way signpost and give way line, and the design of the intersection on this road is also a probable contributing factor.

On the other hand, the evidence of Ms Clark's use of her mobile telephone (which is contrary to Victorian law) immediately prior to the collision is not definitively causal or contributory to the collision but is a timely reminder of the importance of driver hyper-vigilance at all times. This is especially so for relatively inexperienced drivers.

FINDINGS

I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and find that Valerie Beryl McNeil died from multiple injuries (motor vehicle impact – driver) in circumstances where I am satisfied that she has contributed to her own death by failing to give way to an oncoming vehicle.

I direct that these Findings be published on the internet.

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

Mr Darryl McNeil

The Hon. Luke Donnellan MP, Minister for Roads and Road Safety

Mrs Tanja Davis on behalf of the Transport Accident Commission

Ms Karen Macdonald on behalf of VicRoads

South West Healthcare

Senior Constable Andrew McMillan

Signature:

AUDREY JAMIESON
CORONER
Date: **22 January 2015**