IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0893

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**Coroner Darren J Bracken**
Deceased:	**Vicki Evelyn Webster**
Date of birth:	24 February 1953
Date of death:	22 February 2017
Cause of death:	Head injuries sustained in a motor vehicle accident
Place of death:	Near 401 Lake Rowan Road, Lake Rowan, Victoria

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HIS HONOUR:

BACKGROUND

1. When she died on 22 February 2017 Vicki Webster was 63 years old and lived in Bungeet, Victoria. She and her husband separated in 2016 before which Ms Webster took strong analgesics; her husband cared for her during this time. She was a loving and devoted mother who maintained regular contact with her children and grandchildren whom she often 'looked after'.

2. Since she and her husband separated she was said to be visibly happier and looking forward to the future – including the birth of her 10th grandchild on May 2017.[1] Her health improved dramatically – she no longer needed analgesia. She could and did go dancing again and took a more active role in her grandchildren's lives.

3. Ms Webster died only two days before her 64th birthday when the car that she was diving left the Lake Rowan Road and collided with a tree. Ms Webster had plans to have a roast dinner with family to celebrate.

THE CORONIAL INVESTIGATION

Coroners Act 2008

4. Vicki Webster's death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (the **Act**) as his death occurred in Victoria and was unexpected, unnatural and resulted from an accident.[2]

5. The Act requires a Coroner to investigate reportable deaths such as Ms Webster's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[3]

6. For coronial purposes, "*circumstances in which death occurred*"[4] refers to the context and background to the death including the surrounding circumstances, rather than being a

[1] Statement of Rhiannon Davis dated 13 July 2017, Coronial Brief page 26.
[2] *Coroners Act 2008* (Vic) s 4.
[3] *Coroners Act 2008* (Vic) preamble and s 67.

consideration of all circumstances which might form part of a narrative which culminated in the death. Required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

7. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[5] It is not the Coroner's role to determine criminal or civil liability,[6] nor to determine disciplinary matters.

8. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by making recommendations.

9. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[7]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[8] and

   (c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9]

Standard of Proof

10. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[10] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[11] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of

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[4] *Coroners Act 2008* (Vic) s 67(1)(c).
[5] *Keown v Khan* [1999] 1 VR 69.
[6] *Coroners Act 2008* (Vic) s 69 (1).
[7] *Coroners Act 2008* (Vic) s 72(1).
[8] *Coroners Act 2008* (Vic) s 67(3).
[9] *Coroners Act 2008* (Vic) s 72(2).
[10] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[11] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

proof; there is no such thing as a "Briginshaw Standard" or "Briginshaw Test" and use of such terms may mislead.[12]

11. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the finding to be based on those facts.[13] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[14] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[15]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

12. On 22 February 2017 Scott Lambden identified the deceased as his mother-in-law, Vicki Webster.

13. Ms Webster's identity is not disputed and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

14. On 23 February 2017 Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an external examination of Ms Webster's body. Dr Bedford provided a written report, dated 3 March 2017, in which he opined that the cause of death was *"head injuries – motor vehicle accident"*. I accept Dr Bedford's opinion.

15. Toxicological analysis of post mortem samples was negative for ethanol and common drugs and poisons.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

16. On Wednesday 22 February 2017 Ms Davis, asked her mother to come to her house in Lake Rowan to babysit her grandchildren whilst she attended a medical appointment. The plan was

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[12] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

[13] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

for Ms Webster to meet her grandchildren after school when they got off the bus as they did each day at around 4pm. Ms Webster had already prepared dinner, and planned to stay over-night to attend the children's school swimming carnival the next day.

17. Ms Webster left her home in Bungeet Road at about 3.55pm on 22 February turning left into Lake Rowan Road. The road was dry, it was a clear sunny day and driving conditions were good.

18. Ms Webster drove west on Lake Rowan Road and approaching a crest near 401 Lake Rowan Road; a vehicle passed her travelling east. Because of the width of the bitumen road surface both cars needed to (and did) move to their respective lefts to pass each-other. The incident report from the accident notes that the driver of the other car saw Ms Webster and slowed.[16] In her statement to police the driver of this car said that after she passed Ms Webster she looked in the rear-view mirror and saw Ms Webster's car swerving into the middle of the road *"like it was out of control"*.[17]

19. After passing this car Ms Webster moved further to the left; the near side wheels of her car ran over a thick bitumen rise and onto the gravel verge. It appears that Ms Webster overcorrected[18] to the right causing her car to cross the east bound lane, leave the road on the northern side and collide with a tree.

20. Ms Webster's car hit the tree, and the Collision Reconstruction Unit of Victoria Police estimated that shortly before leaving the road Ms Webster's car was travelling at least 89 km/h.[19] The driver of the car that passed Ms Webster shortly before the collision stopped to help and called '000'. At about this time a local couple heard a loud 'bang' and drove to where Ms Webster had hit the tree to try to help. The other driver and others at the scene tried to get to Ms Webster out of the car but they could not open the car doors.

21. The Country Fire Authority arrived at the scene followed by Ambulance, Police and State Emergency Services. Alas, Ms Webster was pronounced deceased at 4.37pm.

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[16] Incident Report, Incident Number T20170003609, Coronial Brief page 64.
[17] Statement of Sally Rice dated13 July 2017, Coronial Brief page 8.
[18] Statement of Detective Leading Senior Constable Robert Hay dated 9 March 2017, Coronial Brief page 21.
[19] Statement of Detective Sergeant Mehegan dated 9 March 2017, Coronial Brief page 21.

22. Ms Webster's car was subsequently inspected by the Mechanical Investigation Unit of Victoria Police Forensic Services. No mechanical faults which would have caused or contributed to the collision were identified.[20]

23. I am satisfied, having considered all the available evidence, that no further investigation into Ms Webster's death is required.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

24. Lake Rowan Road is a country road with some dips and relatively tall crests; the speed limit on the part of the road on which this collision occurred is 100 km/h. The road is 4.6m wide with a drop-off of about 5 centimetres from the bitumen to a 1.7m gravel edge.[21]

25. Whilst Ms Webster's motor vehicle accident was the only reported accident on Lake Rowan Road during the 10 years immediately preceding it,[22] the road is not wide enough for two vehicles to pass each other safely on the bitumen surface.[23] The crests referred to in paragraph 24 limit the distance drives can see.

Response to the Accident by Moira Shire Council

26. In June 2017, some four months after the accident the Moira Shire Council (the **Council**) placed traffic counters on Lake Rowan road to record traffic volumes and measure the average speed of drivers. In June 2018 the Council received an email from a Regional Director of VicRoads inviting the Council to submit road safety improvement proposals relating to municipal roads for consideration under the Federal Government's 2018 to 2019 'Black Spot' program, however the Council determined[24] that it was not able to use Ms Webster's accident as support for such funding because it occurred outside the time frame nominated in the program.[25]

27. Whilst VicRoads is the body responsible for speed signs, 'stop' and 'give way' signs,[26] the Council can independently install other road signs such as warning signs. I note that rural roads have a default 100km/h speed limit,[27] which VicRoads alone may vary.[28]

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[20] Statement of Senior Constable Brett Gardener dated 4 April 2017, Coronial Brief page 19.
[21] Statement of Senior Constable Brent Yearwood dated 28 August 2017, Coronial Brief page 31.
[22] VicRoads Road Crash Report for Lake Rowan Road for the period 13 April 2008 to 13 April 2018.
[23] Statement of Senior Constable Brent Yearwood dated 28 August 2017, Coronial Brief page 31 at page 33.
[24] On advice from VicRoads and the Council's traffic consultants, Traffic Works Pty Ltd.
[25] Statement of Graham Henderson, Moira Shire Council, dated 26 July 2018 at page 3.
[26] *Road Management Act 2004* (Vic) s 37(2); *Road Safety (Traffic Management) Regulations 2009* (Vic) regs 7 & 8.
[27] *Road Safety Road Rules 2017* (Vic) Regulation 25(3)

28. On 26 July 2018, some 17 months after the collision, the Council installed 60 kilometres per hour advisory speed signs and 'crest' warning signs on Lake Rowan Road between Big Hill and Howell's Road (the vicinity of Ms Webster's collision) and on 2 August 2018, guideposts were installed in the same location.

29. I note that the modifications listed above in paragraph 28 had been in place since only April 2018, with the Council having only provided its initial instructions to a Design Engineer to undertake an investigation of the crash site in May 2017.[29] This was some two and a half months after Ms Webster's fatal accident.

30. In September 2018 the Victorian State Government announced the 'Fixing Country Roads Program'. The Council made an application for three projects, including the widening of five kilometres of Lake Rowan Road from the Benalla Yarrawonga Road through to Miller Road. This includes the site of Ms Webster's accident. On 29 October 2018 the Council was informed that its application for funding was successful. I am told that the works are planned to be completed prior to 30 June 2019.[30]

RECOMMENDATIONS

31. Pursuant to section 72(2) of the Act and with a view to improve public health and safety in particular the safety of road users on Lake Rowan Road **I recommend that**:

    1. VicRoads post speed limit signs on each side of the crest on Lake Rowan Road immediately in the vicinity of Ms Webster's accident scene (near Howells Road) reducing the approach speed to less than 100 km/h pursuant to section 8 of the *Road Safety (Traffic Management) Regulations 2009* (Vic).

    2. VicRoads consider implementing the strategy referred to in Recommendation 1 in relation to the other crest on Lake Rowan Road (and its continuation as Boweya-st James Road) between Big Hill Road and Bungeet Road.

    3. The Council, with the support of VicRoads, widen approaches to and the road on the crest in Lake Rowan Road in the vicinity of Ms Webster's accident scene near Howells Road be widened as soon as possible

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[28] *Road Safety (Traffic Management) Regulations 2009,* s 8.
[29] Statement of Graham Henderson, Moira Shire Council, dated 26 July 2018 at page 3.
[30] Statement of Graham Henderson, Moira Shire Council dated 22 November 2018.

4. The Council, within three months of receiving this Finding post 'crest' warning signs and speed advisory signs as referred to in paragraph 30 above on the crest on Lake Rowan Road (and its continuation as Boweya-st James Road) between Big Hill Road and Bungeet Road.

FINDINGS AND CONCLUSION

32. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Vicki Evelyn Webster, born 22 February 1953;

    (b) Ms Webster's death occurred:

        (i) on 22 February 2017 near 401 Lake Rowan Road, Lake Rowan, Victoria;

        (ii) from head injuries sustain in a motor vehicle accident; and

    (c) in the circumstances set out in paragraphs 16 to 23 above

33. Pursuant to section 73(1A) of the Act I order that this Finding be published on the internet.

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

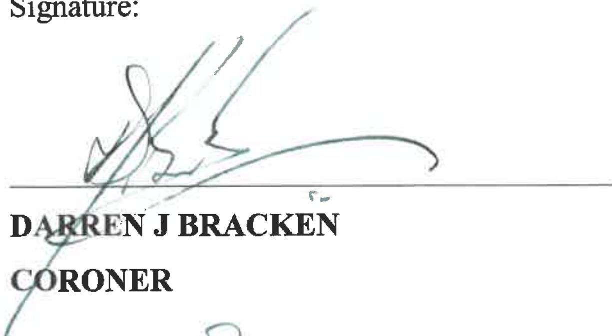
    (a) Ms Rhiannon Davis, Senior Next of Kin;

    (b) Mr Graham Henderson, Manager, Construction and Assets, Moira Shire Council;

    (c) Michael Kyriakakis, Principle Lawyer, VicRoads; and

    (d) Senior Constable Brent Yearwood, Coroner's Investigator, Victoria Police.

Signature:



DARREN J BRACKEN
CORONER

Date: 20 December 2018