IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3063

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**DAVID ROBERT ANCEL GREEN**
Date of birth:	9 November 1981
Date of death:	27 June 2018
Cause of death:	1(a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT
Place of death:	Intersection of Spences Road and Numurkah Road, Katunga, Victoria

HER HONOUR:

Background

1. David Robert Ancel Green was born on 9 November 1981. He was 36 years old when he died on 27 June 2018 from multiple injuries sustained in a motor vehicle accident.

2. Mr Green's parents described their son as a loving, intelligent, and happy-go-lucky person. He was a nature lover and made his life an adventure, spending 12 years in China. It is evident that he was much loved and respected.

3. At Christmas 2017, Mr Green obtained his New South Wales driver's licence. About a week before he died he drove his van to Victoria to look for work, finding some on a tomato farm in Katunga.

The coronial investigation

4. Mr Green's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

6. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Green's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

9. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

10. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

11. Mr Green was identified by his fingerprints and circumstantial evidence. Identity was not in issue and required no further investigation.

Medical cause of death

12. On 29 June 2018, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of Mr Green and reviewed a post mortem computed tomography (CT) scan.

13. The autopsy revealed multiple significant injuries.

14. Toxicological analysis of post mortem specimens taken from Mr Green identified 11-nor-delta-9-carboxy-tetrahydrocannabinol (cannabis).

15. After reviewing toxicology results, Dr Parsons completed a report, dated 7 August 2018, in which she formulated the cause of death as "*1(a) Multiple injuries sustained in a motor vehicle incident*". I accept Dr Parsons's opinion as to the medical cause of death.

Circumstances in which the death occurred

16. On 25 June 2018, Green commenced working at a tomato farm. The next day his employers spoke to him about the fact he had been seen driving through a give way sign at the intersection of Spences Road and Katunga North Road. He indicated he had not even seen the sign.

17. On the afternoon of 27 June 2018, Mr Green finished work at 1.25pm. It was a clear day. He was later seen at the intersection of Spences Road and Katunga North Road, before heading east on Spences Road towards Numurkah Road.

18. Spences Road is a minor road with a bitumen surface in reasonable condition. It is not a divided road; road users must use the gravel edge when passing one another. The road runs straight in an east-west direction. The speed limit is 100 kilometres per hour. A raised channel runs along the northern side of Spences Road.

19. As Mr Green was approaching the intersection of Spences Road and Numurkah Road, a semi-trailer (**the truck**) was also approaching the intersection from the north on Numurkah Road at a speed of about 100 kilometres per hour.

20. Approximately 110 metres prior to the intersection with Numurkah Road Mr Green would have passed a stop advisory sign and approximately 10 metres before the intersection, there was a stop sign. At the intersection, there was also a painted line requiring road users on Spences Road to stop.

21. However, for most of the 120 metres leading up to the intersection Mr Green's view of Numurkah Road would have been obscured by the channel, together with thick vegetation along the side of the road.

22. Numurkah Road is a divided road with a single lane of bitumen road surface in both directions. It is in good condition. The road has a gravel shoulder, which is also in good condition. The speed limit is 100 kilometres per hour. It runs in a straight north-south direction. At the intersection with Spences Road, road users on Numurkah Road have the right of way.

23. Like Mr Green, for most of the 150 metres leading up to the intersection the truck driver's view of Spences Road would have been obscured by thick vegetation on the western side of Numurkah Road.

24. The truck was fitted with a dash camera, which revealed that Mr Green's van drove into the intersection and into the path of the truck without stopping or noticeably slowing.

25. The truck collided with Mr Green's vehicle. Both vehicles remained on their wheels and headed in a southerly direction for approximately 75 metres before coming to a rest.

26. Mr Green appears to have passed away immediately upon impact.

27. According to Senior Constable Andrew Costello, Coroner's Investigator, the dash cam footage revealed that there was less than two seconds when either vehicle would have had vision of the other. Skid marks at the scene indicate that the truck driver braked, but only about six metres prior to impact.

28. A mechanical inspection of Mr Green's vehicle conducted by Victoria Police did not reveal any mechanical fault or failure that would have caused, or contributed to, the collision.

29. Mr Green's family described his death as an untimely and terrible tragedy, which it indeed was. I convey my sincere condolences to Mr Green's family.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was David Robert Ancel Green, born 9 November 1981;

(b) Mr Green died on 27 June 2018 at the intersection of Spences Road and Numurkah Road, Katunga, Victoria, from multiple injuries sustained in a motor vehicle incident; and

(c) the death occurred in the circumstances described above.

Comments

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments in connection with the death:

1. Mr Green was an inexperienced driver in relatively unfamiliar territory. The truck driver had also never travelled that route before. Whilst the direct cause of the collision was Mr Green's failure to stop at the stop sign, it is possible that better visibility of the intersection from either direction may have prevented the collision altogether or at least reduced the severity of the impact.

2. I have previously investigated another road death which occurred in similar circumstances, that is where the view of an intersecting country road was obscured by a wind break

comprised of trees and an elevated ditch.[2] In that matter I recommended the local shire review the design and layout of the intersection in light of several suggested improvements, two of which are relevant in this case, namely:

(a) that a speed limit sign be posted approximately 200 metres from the intersection in both directions, with a reduced speed limit of 80 kilometres per hour for drivers travelling through the intersection; and

(b) that tree lines approaching the intersection be removed to improve the line of sight of drivers approaching the intersection.

3. I recognise that there may be good reason for vegetation along sides of country roads, but there is also a need to reduce any hazard posed by that vegetation. If the trees are preserved, other measures may need to be introduced to ensure that public safety is not jeopardised, such as flashing stop signs, which could be solar powered, or rumble strips on the approach to the intersection.

Recommendation

Pursuant to section 72(2)) of the *Coroners Act 2008*, I recommend that Moira Shire Council review the safety of the intersection of Spences Road and Numurkah Road Katunga in light of the circumstances of this collision and the comments above.

Publication

Given that I have made a recommendation, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

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

Brigitta Green, Senior Next of Kin
Robert Green, Senior Next of Kin
Moira Shire Council
Cardinia Shire Council
Senior Constable Andrew Costello, Coroner's Investigator, Victoria Police

[2] Finding into the death of Nicole Chatfield COR 2016 5068, published on the Coroners Court website. No response to the recommendation from the Cardinia Shire Council has been received to date.

Signature:

ROSEMARY CARLIN
CORONER
Date: 4 March 2019.