IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4304

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**Coroner Darren J. Bracken**
Deceased:	**Marcus Leon Hurst**
Date of birth:	5 February 1968
Date of death:	29 August 2017
Cause of death:	Head injuries sustained in a motorcycle incident (driver)
Place of death:	Williamstown Road, Yarraville, Victoria

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HIS HONOUR:

BACKGROUND

1. On 16 January 2018 Mr Hurst was 49 years old when the motor cycle that he was riding collided with a parked truck in Williamstown Road Yarraville. Mr Hurst is likely to have died immediately. At the time of his death Mr Hurst worked as a security guard and was riding home having finished work at approximately 5.45am. Mr Hurst lived alone in Footscray and was divorced, with three children, Josh, Kiara and Noah.

2. Mr Hurst was a quiet, reserved man who did not like conflict and was accepting of everyone. He had a good relationship with his children and enjoyed spending time with them. He was an avid motorcycle rider and had ridden motorcycles since he was 15 years old.[1]

3. Mr Hurst had a medical history of bipolar disorder dating back to his early 20s for which he was prescribed medication.[2]

THE CORONIAL INVESTIGATION

Coroners Act 2008

4. Mr Hurst's death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (the **Act**) as his death occurred in Victoria, was unexpected, resulted from an accident and was not from natural causes.[3]

5. The Act requires a Coroner to investigate reportable deaths such as Mr Hurst'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.[4]

6. For coronial purposes, "*circumstances in which death occurred*"[5] refers to the context and background to the death including the surrounding circumstances, rather than being a consideration of all circumstances which might form part of a narrative which culminated in

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[1] Coronial Brief, Statement of Josh Hurst dated 18 November 2017, page 56.
[2] Coronial Brief, Statement of Josh Hurst dated 18 November 2017, page 57.
[3] Coroners Act 2008 (Vic) s 4.
[4] *Coroners Act 2008* (Vic) preamble and s 67.
[5] *Coroners Act 2008* (Vic) s 67(1)(c).

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.[6] It is not the Coroner's role to determine criminal or civil liability,[7] 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;[8]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[9] 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.[10]

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*.[11] 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.[12] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of

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6 *Keown v Khan* [1999] 1 VR 69.
7 *Coroners Act 2008* (Vic) s 69 (1).
8 *Coroners Act 2008* (Vic) s 72(1).
9 *Coroners Act 2008* (Vic) s 67(3).
10 *Coroners Act 2008* (Vic) s 72(2).
11 (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.
12 *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.[13]

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.[14] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[15] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16]

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

12. On 30 August 2017, the Fingerprint Branch of the Victoria Police Forensic Services Department matched the left index finger imprint of the deceased with the fingerprint on record for Marcus Leon Hurst, born 5 February 1968.

13. I am satisfied that the deceased is Marcus Leon Hurst, born 5 February 1968.

Medical cause of death, pursuant to section 67(1)(b) of the Act

14. On 30 August 2017, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr Hurst's body. Dr Young drew a written report, dated 4 September 2017, in which he opined that Mr Hurst died from *"head injuries sustained in a motorcycle incident (driver)"*.

15. Toxicological analysis of post mortem samples taken from Mr Hurst identified the presence of codeine, venlafaxine and desmethylvenlafaxine at levels consistent with therapeutic use.

16. Dr Young commented that the post mortem CT scan revealed extensive fractures involving the facial and skull bones. He opined that the head injuries were significant, and would have been rapidly fatal.

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

[14] 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.

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

[16] 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.

17. I accept the cause of death proposed by Dr Young.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. In the early hours of Tuesday 29 August 2017 Mr Hurst completed a 12-hour night shift working as a security guard at the Melbourne International Rollon - Rolloff Automotive Terminal in Port Melbourne. He left the facility at approximately 5.45am, intending to ride his motorcycle home to Footscray.[17]

19. At approximately 5.45am, Mr Jaiveer was driving a container transport truck north bound on Williamstown Road in Yarraville.[18] The truck was attached to an empty semi-trailer which incorporated a hydraulic crane to load and unload containers.[19] Mr Jaiveer parked his truck in the left hand lane of Williamstown Road, approximately 90 metres south of the intersection with Somerville Road.[20]

20. Mr Jaiveer sat in the cabin for approximately four minutes when he heard *"a very loud noise and a smash. It sounded like a very loud exhaust and then a smashing sound"*.[21] Mr Jaiveer alighted from the truck and found Mr Hurst and his motorcycle on the ground at the very back of his truck.[22]

21. Mr Jaiveer contacted emergency services who arrived shortly afterwards.[23] Ambulance paramedics pronounced Mr Hurst deceased at 6.10am.[24]

22. Williamstown Road is a single carriageway with two lanes each for north and south bound traffic. In the vicinity of the collision the roadway is a sealed straight road. It is reasonably well maintained with good visibility in both directions. At the time of the collision the road was damp but drying in places and the weather was clear and fine.[25] It was still dark, just prior to the break of dawn. The street lighting in the vicinity of the collision was on and operated by light sensors on the lampposts.[26]

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17 Coronial Brief, Summary, page 2.
18 Coronial Brief, Statement of Jaiveer dated 29 August 2017, pages 48-49.
19 Coronial Brief, Statement of Senior Constable Adam Jones dated 11 January 2018, page 61.
20 Coronial Brief, Statement of Jaiveer dated 29 August 2017, pages 48-49; Coronial Brief, Statement of Senior Constable Adam Jones dated 11 January 2018, page 60.
21 Coronial Brief, Statement of Jaiveer dated 29 August 2017, page 49.
22 Ibid, pages 49-50.
23 Ibid, page 50.
24 Coronial Biref, VACIS Electronic Patient Care Record dated 29 August 2017, page 39.
25 Coronial Brief, Statement of Senior Constable Adam Jones dated 11 January 2018, page 60.
26 Statement of Senior Constable Adam Jones dated 11 January 2018, page 60; Email correspondence from Hayley Strauss, Jemena dated 10 January 2019.

23. Senior Constable Jones observed that the rear of the trailer was painted black and was quite dirty. The few rear reflective surfaces were covered in a layer of road grime.[27] Senior Constable Jones observed damage to the motorcycle consistent with an impact to the rear of the trailer and damage to the offside rear of the truck consistent with impact from Mr Hurst and his motorcycle.[28] The damage to the motorcycle indicated the motorcycle was travelling in a straight line at the point of impact.[29] He observed that the truck and trailer were legally parked as close as practicable to the left side of the road.[30] There were no visible skid marks attributable to Mr Hurst's motorcycle.[31] Given the damage observed on the motorcycle and the trailer and the location of the motorcycle's resting point in relation to the trailer, Senior Constable Jones opined that at the time of the collision Mr Hurst was travelling at or under the speed limit of 60km/hr.[32] Senior Constable Jones inspected Mr Hurst's motorcycle and helmet. He did not identify any obvious mechanical faults with the motorcycle or the helmet that would have caused or contributed to the collision or Mr Hurst's death.[33]

24. Given the circumstances, a straight road, no skid marks or signs that Mr Hurst sought to avoid the truck and the speed of Mr Hurst's motorcycle when it hit the truck it is likely that Mr Hurst just didn't see the parked truck.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

25. Mr Hurst sustained substantial facial injuries as a result of the collision. At the time of the collision he was wearing an RXT classic open face helmet that complied with Australian standards.[34] Studies indicate that compared with full-face helmets, open-face helmets are associated with a higher occurrence of head injury.[35] Full-face helmets appear to have a preventive effect on severe head injury and are known to reduce the incident of head injury, brain contusion and craniofacial fractures.[36] Full face helmets may increase the survivability of motorcycle riders as they can offer significant impact protection to the frontal and orbital regions of the face and assist in distributing the impact throughout the helmet, as opposed to

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27 Ibid, page 61.
28 Ibid.
29 Coronial Brief, Photograph 13, page 74.
30 Ibid.
31 Coronial Brief, Traffic Incident System Incident Report dated 29 August 2017, page 89.
32 Coronial Brief, Photograph 4, page 69.
33 Coronial Brief, Summary, page 9.
34 Coronial Brief, Summary, page 12.
35 Taryn Erhadt et al, 'Motorcycle helmet type and the risk of head injury and neck injury during motorcycle collisions in California' (2016) 86 *Accident Analysis and Prevention* 23, pages 24-25.
36 Ibid.

through the face and skull.[37] However, I am unaware of any evidence supporting the contention that a full-face helmet would or could have made a difference to Mr Hurst.

26. The visibility of the trailer may have been a contributing factor in the collision. The trailer frame was painted a dark blue colour, the crane arm was black in colour and the rearward warning signs and tail light reflectors of the trailer were partially obscured due to road grime.[38] The human eye relies on luminance and contrast to distinguish objects from their background. Objects are more conspicuous and easier to detect where there is a higher contrast. In dark surroundings, contrast sensitivity is reduced, and it is more difficult to detect objects from the background, such as trucks or trailers at night.[39]

27. The United Nations Economic Commission for Europe (**UNECE**) has harmonised vehicle regulations relating to the visibility requirements of the rear and sides of heavy vehicles. The regulations mandate the use of retroreflective tapes on heavy trucks and their trailers. The regulations offer guidance for the marking shape and mounting requirements, which includes the implementation of contour markings intended to indicate the length, width and height dimensions of a vehicle to increase the conspicuity of a vehicle when viewed from the side or rear.[40] The European Union has adopted these regulations in full, implementing mandatory conspicuity markings for heavy goods vehicles and trailers in all member states from July 2011.[41] The United States of America has also mandated conspicuity markings on both new and existing trailers over 4.5 tonnes.[42] The Australian Vehicle Standard has adopted the UNECE provisions in full, but has amended the provisions regarding conspicuity markings to allow such markings to be optional, rather than mandatory.[43]

28. In the United States of America, studies have found a significant decline in the risk of night time rear end and angle crashes into heavy trucks following the introduction of truck

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37 Harry Hurt et al, *Motorcycle Accident Cause Factors and Identification of Countermeasures Volume 1: Technical Report* (January 1981), page 299.

38 Coronial Brief, Photograph 3, p.69

39 Agota Berces, 'Improving Road Safety by Increased Truck Visibility' 3M Traffic Safety Systems Division, NSW, pages 5-6.

40 Regulation No. 48 (2008) 'Uniform provisions concerning the approval of vehicles with regard to the installation of lighting and light-signalling devices' Rev.1/Add.47/Rev.5 United Nations; Regulation No. 104 (1998) 'Uniform provisions concerning the approval of retro-reflective markings for heavy and long vehicles and their trailers' Rev.2/Add.103, United Nations.

41 Agota Berces, 'Improving Road Safety by Increased Truck Visibility' 3M Traffic Safety Systems Division, NSW, page 7

42 Ibid, page 8.

43 ADR 13/00 Standards/Australian Design Rules for Vehicles as amended, taking into account amendments up to Vehicle Standard (Australian Rule 13/00 – Installation of Lighting and Light Signalling Devices on other than L-Group Vehicles) 2005 Amendment 6, para 10.14.1.

conspicuity treatments.[44] A truck with outline reflective markings is recognised much earlier than an unmarked truck because they assist in defining the total size of the truck to other road users.[45] The risk of a motor vehicle collision with a truck is significantly greater when the truck does not have high visibility markings.[46] The use of conspicuity treatments has been found to reduce rear impact collisions by about 43%.[47]

29. In August 2016, the Australian Trucking Association issued a Heavy Vehicle Visibility Technical Advisory Procedure (TAP) to assist the road transport industry to improve the visibility of heavy commercial trucks and trailers.[48] The TAP encourages operators of heavy commercial trucks and trailers to follow the provisions in Europe regarding use of contour retroreflective markings on trucks and trailers to increase vehicle visibility.[49] However, the implementation of the TAP is a voluntary, industry-led recommendation. There is no requirement for heavy vehicles and trailers to have rear or side facing contour markings, despite evidence that contour retroreflective markings are cost effective and may assist in preventing truck crashes and fatalities by increasing their visibility.[50]

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

30. In the interests of public health and safety and preventing like deaths, **I recommend** the Australian Government Department of Infrastructure, Regional Development and Cities consider amending vehicle standards to mandate the use of conspicuity markings for heavy vehicles and trailers in line with international standards to improve road safety for all Australian road users.

FINDINGS AND CONCLUSION

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

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44 John Sullivan and Michael Flannagan, 'Heavy Trucks, Conspicuity Treatment, and the Decline of Collision Risk in Darkness' (2012) 43 *Journal of Safety Research* 157, page 161.

45 Australian Trucking Association, 'Heavy Vehicle Visibility: Technical Advisory Procedure' (August 2016) 2nd edition, page 5.

46 Ibid.

47 John Sullivan and Michael Flannagan, 'Heavy Trucks, Conspicuity Treatment, and the Decline of Collision Risk in Darkness' (2012) 43 *Journal of Safety Research* 157, page 160.

48 Australian Trucking Association, 'Heavy Vehicle Visibility: Technical Advisory Procedure' (August 2016) 2nd edition.

49 Ibid, pages 4-5.

50 Agota Berces, 'Improving Road Safety by Increased Truck Visibility' 3M Traffic Safety Systems Division, NSW, pages 9-10.

(a) the identity of the deceased was Marcus Leon Hurst, born 5 February 1968;

(b) the death occurred on Williamstown Road at Yarraville, Victoria, from head injuries sustained in a motorcycle incident (driver); and

(c) the death occurred in the circumstances described above at paragraphs 18 to 24.

32. I convey my sincerest sympathy to Mr Hurst's family.

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

(a) Mr Joshua Hurst, Senior Next of Kin;

(b) Senior Constable Adam Jones, Victoria Police, Coroner's Investigator;

(c) The Department of Infrastructure, Regional Development and Cities, Australian Government; and

(d) Transport Accident Commission.

Signature:

DARREN J. BRACKEN
CORONER
Date: 28 March 2019.