



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 2892

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Mr AJ
Date of birth:	21 February 1989
Date of death:	6 June 2019
Cause of death:	1(a) Traumatic haemothorax sustained in a motorbike collision
Place of death:	Hallam Road (between Centre Road and Blackwood Road), Hampton Park, Victoria 3803

INTRODUCTION

1. Mr AJ was 30 years old when he was involved in motor vehicle collision on 6 June 2019, in which his motorcycle collided with the rear of another vehicle on Hallam Road, Hampton Park, between Centre and Blackwood Roads. At the time, Mr AJ lived in Cranbourne North with his partner, Ms AA, and their daughter.

THE CORONIAL INVESTIGATION

2. Mr AJ'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.
3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
4. 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.
5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr AJ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. In addition to several statements and scene photographs, the vehicles involved in the collision were inspected by Victoria Police, Mechanical Investigation Unit. A report of the mechanical investigation findings was prepared for the coronial investigation and has been considered in this finding.
6. This finding draws on the totality of the coronial investigation into the death of Mr AJ, including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

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

Identity of the deceased

7. On 6 June 2019, Mr AJ, born 21 February 1989, was visually identified by his father who signed a Statement of Identification to this effect.
8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination on 7 June 2019 and provided a written report of her findings dated 23 July 2019.
10. The post-mortem examination showed findings in keeping with the clinical history. Examination of the post-mortem CT scan showed a right acetabular, femoral and tibial fractures and a large left haemothorax without rib fractures.
11. Dr Baber opined that the large left haemothorax was most likely due to the rupture of a great vessel, which would be in keeping with a high-speed rapid deceleration injury. Dr Baber recommended a partial autopsy be conducted, to which Mr AJ's family raised strong objections. In deference to their wished no autopsy, partial or otherwise was performed.
12. Routine toxicological analysis of post-mortem samples was undertaken and detected methylamphetamine and its metabolite amphetamine² and delta-9-tetrahydrocannabinol³.
13. Dr Baber provided an opinion that it would be reasonable to attributed Mr AJs death to *I(a) Traumatic injuries sustained in a motorbike collision*, without an autopsy.

¹ 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.

² Amphetamines is a collective word to describe central nervous system (CNS) stimulants. One of these, methamphetamine, is often known as "speed" or "ice".

³ Δ^9 -tetrahydrocannabinol (TCH) is the active form of cannabis.

Circumstances in which the death occurred

14. On 6 June 2019 at approximately 4.27pm, closed circuit television captured Mr AJ riding in a manner described as “intentional high-risk driving” as he entered the premises of Caprice Plaster located on Rimfire Drive. Mr AJ was riding his Kawasaki Z1000⁴ (**motorcycle**).
15. At approximately 4.30pm, Wayne Goulett witnessed Mr AJ exiting the driveway of Caprice Plaster – *“As the motorbike hit the bitumen road, I heard the rider floor it.”*
16. Mr AJ turned onto Rimfire Drive and accelerated heavily, causing the rear tyre of his motorcycle to break traction and produce a large amount of smoke. Mr AJ continued to accelerate heavily, causing the motorcycle to *“fishtail”* up the road *“as he tried to control the bike. The rear of the bike went from side to side as the rider kept accelerating”*. Mr AJ looked to be out of control of the motorcycle, with Mr Goulett detailing that he looked as though he was about to collide into a parked vehicle.
17. Another witness, Wayne Decker, also observed Mr AJ exiting Caprice Plaster. He recalled hearing the motorbike being revved *“pretty hard”* and seeing a large amount of smoke coming from the rear wheel.
18. After leaving Caprice Plaster, Mr AJ was observed by Douglas Smith travelling along Centre Road towards Hallam Road. Mr Smith travelled in his own vehicle behind Mr AJ for a period before losing sight of him as the motorcycle turned left onto Hallam Road. According to Mr Smith, traffic was flowing *“relatively well”* at the time.
19. Some 150 metres along Hallam Road, Mr Smith observed a 1993 Holden Commodore sedan (**Holden**) positioned perpendicular across the two lanes of Hallam Road.
20. At about 4.45pm, Mr Smith observed the Holden being struck mid-U-turn. The force of the impact caused the Holden to spin into the northbound lane of Hallam Road. At first, Mr Smith was not certain exactly what had struck the Holden. It was not until he drove closer that he realised the Holden had been struck by Mr AJ’s motorcycle.
21. Dominique Freeman and Fengyin Chen were all driving their vehicles south along Hallam Road at the time of the collision. Ms Freeman was in front of the Holden, while Ms Chen was travelling directly behind it.

⁴ Appears to have been a 2010-2013 model. It is probable that based on the identifying features located on the centre hubs of the front and rear rims, being speed sensors, that the motorbike was factory fitted with ABS braking, possibly making it a 2013 model.

22. According to Ms Freeman, prior to the collision she was driving south along Hallam Road, when she looked in her rear view mirror and noted the Holden attempting to do what appeared to be a U-turn so as to travel back in a northerly direction along Hallam Road towards the Princess Highway. She was following the Holden when she saw its right indicator go on. At the same time, Ms Chen observed the motorcycle overtaking her to the right side of her vehicle.
23. Jaqueline Tonkin was driving behind Ms Chen and stated that she had been startled by the close proximity of the motorbike passing her – *“The motorbike has gone past me, causing me to take a deep breath from the closeness and the speed that it went past me... I would say the rider was about 15 centimetres away from the right side of my car. I was surprised that the rider didn’t hit my side mirror.”*
24. Ms Tonkin estimated that she had been travelling at approximately 60 kilometres an hour and that the motorcycle was travelling at approximately 70 kilometres an hour.
25. The driver of the Holden (**the driver**) stated that they drove approximately 350-400 metres along Hallam Road before they slowed down to do a right-hand U-turn across the broken lines. When an oncoming car slowed to allow the Holden to U-turn into their path, the driver commenced moving with their right indicator activated at the time. They estimated travelling between 10-20 kilometres an hour as they commenced their U-turn when they felt a *“huge bang”*. The driver described the impact as feeling *“like a meteorite hit my car”*.⁵
26. Ms Freeman detailed hearing a *“loud bang”* and looking in her rear view mirror to see a motorcyclist propelling through the air *“about bonnet height of a car, covering a distance of about 2-3 metres in the air, before landing on the road and skidding a further 3-4 metres along the road”*. Mr Smith also witnessed the Holden being struck mid-turn as it appeared to be performing a U-turn.
27. Just prior to impact, Christopher Van Gunst stated that he saw the motorcycle deviate right and onto the opposite side of Hallam Road. His view was partly obscured by the cars in front of him, but he did see the motorcycle as it began to veer into the north bound lane. Mr Van Gunst further stated that he saw the motorcycle *“wobble”*, as though it was out of control as it approached the Holden.

⁵ The driver stated that when they commenced the U-turn, they did so from the south bound lane without turning off the road or veering left to do the turn.

28. While Mr Smith did not see exactly what had struck the Holden, he stated that it was obvious the Holden had been struck mid-turn as it appeared to be performing a U-turn.
29. Ms Tonkin, Ms Chen, Mr Van Gunst, Mr Smith and the driver all stopped to render assistance to Mr AJ, who was lying on the gravel shoulder on the east side of Hallam Road. Ms Freeman continued her journey home but contacted emergency services to report the collision.
30. Mr AJ was in a semi-conscious but non-responsive state. He was wearing black motorbike clothing, including gloves and a motorbike helmet.
31. A pedestrian also stopped to render assistance at the instruction of the emergency services call operator. He stated that Mr AJ's eyes were open but he was not breathing when cardiopulmonary resuscitation was commenced (**CPR**). While CPR was being performed, Ambulance Victoria (**AV**) paramedics who were passing stopped and took over.
32. At about 5.00pm, an AV Mobile Intensive Care Ambulance (**MICA**) attended and assisted the two AV ambulance crews already in attendance. Mr AJ had dilated pupils, was in cardiac arrest and was not showing any signs of spontaneous respiratory effort. The paramedics intubated Mr AJ was intubated and aligned his injured right leg with splinting. At 5.23pm, after there was no response to half an hour of CPR, Mr AJ was formally declared deceased by attending AV paramedics.
33. In response to the call to emergency services, Victoria Police members attended the scene and immediately commenced an investigation. They noted that it was an overcast afternoon but that conditions were clear with good visibility. They observed the motorcycle lying on its side in a north-westerly direction. The collision scene was on Hallam Road, about 200 metres south of Centre Road and 240 metres north of Blackwood Road.
34. Hallam Road is bi-directional and consists of two marked lanes running in either direction. In the vicinity of the collision, it is a straight length of road that travels generally north-south. Traffic is divided by a single broken white dividing line that becomes a solid white dividing line south of the scene of the collision. Each lane is about 3.6 metres wide. The edge of the road is defined by a solid white fog line and does not have a gutter and curb on either side. lines. The surface is sealed bitumen and was dry and in good condition.
35. Investigating officers noted that the point of impact was in the northbound lane of Hallam Road, indicated by a gouge mark in the bitumen surface, next to the dividing line and a skid

mark also in the northbound lane. Debris was observed eight metres south-east from the point of impact. Mr AJ's body was about 11.9 metres south of debris belonging to the motorcycle and about 3.6 metres from the edge of the roadway and the motorcycle was about 15.6 metres south of Mr AJ's body.

36. The Holden was observed to be facing in an easterly direction on the gravel shoulder on the west side of Hallam Road. Its front wheels and one rear wheel were on the gravel shoulder while the other rear wheel was on the footpath. The Holden's rear bumper bar was completely dislodged and there was other significant body damage indicating the force of impact from the motorcycle.
37. There were two tyre scuff marks next to the front and rear off-side tyres that extended along the gravel shoulder. Tyre scuff marks were also observed in the southbound lane, in an arc from the edge of the roadway around in a clockwise direction, crossing the centre dividing line and extending about half-way across the northbound lane. The front of the Holden was about 4.7 metres from the centre of Hallam Road.
38. The police ascertained that in addition to the driver; Ms Freeman, Ms Tonkin, Ms Chen and Mr Smith were also driving south along Hallam Road prior to the collision. The cars were driving in the following order: Ms Freeman in the lead, followed by the Holden driver, then Ms Chen, Ms Tonkin and Mr Smith. They each told police they were driving at or under the permitted maximum speed of 60 kilometres per hour.
39. Prior to the collision, both Ms Tokin and Ms Chen observed the motorcycle overtaking them to their right, veering into the lane for oncoming traffic. Ms Tonkin stated that she had been "*startled*" by its close proximity. She estimated that the motorcycle was travelling at about 70 kilometres per hour. Ms Chen stated that she saw the motorcycle coming from her right side when the Holden commenced its U-turn, consistent with the driver's account that he was driving at about 10-20 kilometres per hour during the U-turn before hearing the impact.
40. The driver of the Holden underwent a preliminary breath test at the scene which returned negative results for the presence of alcohol. Subsequent testing found no ethanol or any other commonly encountered drugs or poisons in the blood sample taken from the Holden driver.
41. At the time of his death, Mr AJ was the holder of a current Victorian Driver's Licence. He was not the holder, nor had he ever been the holder of a Victorian Motorcycle Licence or learner's permit. Despite statements indicating that Mr AJ had a keen interest in

motorcycles and had grown up riding both dirt bikes and road bikes, he was not legally permitted to ride a motorcycle on a Victorian road.

42. Moreover, investigations revealed that the motorcycle was not registered; Mr AJ did not hold an unregistered vehicle permit; and the rear number plate had not been issued by the Department of Transport-VicRoads (**VicRoads**). Police at the scene ascertained that the Vehicle Identification Number (**V.I.N.**) had been removed from the motorcycle; it was not fitted with rear indicators or rear view mirrors (and was therefore unable to be registered); the tyres were worn to the extent that the tread wear indicators had come into contact with the road's surface; an after-market exhaust and handlebar steering damper kit had been fitted; and the brake lines connecting to the antilock brake system (**ABS**) control module had been cut, a modification that would have meant that the ABS was not operational.
43. The motorcycle sustained moderate impact damage with the initial point of impact being determined to be off-side frame as indicated by the transfer of red paint.
44. Police also inspected the Holden and did not identify any mechanical defects or faults that would have caused or contributed to the collision.

FURTHER INVESTIGATIONS

45. Following review of the coronial brief, I attended a "view" of the scene on 9 October 2019 in the company of LSC Duncan McKenzie from the Police Coronial Support Unit, the coronial investigator and his partner, and Ms Nguyen from VicRoads. My intention was to better understand the flow of traffic in the area and any road infrastructure or other issues that may have caused or contributed to the collision in which Mr AJ sustained fatal injuries.
46. While it was apparent that the primary causal factor was the manner in which Mr AJ rode his motorcycle immediately before the collision with the Holden, the local knowledge of the coronial investigator and his partner, and our own observations during the view suggest that the collision occurred within a particular context. During peak traffic conditions, vehicles wanting to turn right from Centre Road into Hallam Road, perhaps to access Princes Highway, can be delayed inordinately by heavy traffic already on Hallam Road heading north. It appears that drivers faced with this problem, sometimes choose to turn left from Centre Road onto Hallam Road, with the intention of making a U-turn when they can to continue north, rather than wait for a gap in the traffic to allow them to complete a right turn from Centre Road onto Hallam Road in the first place.

47. At this location, Hallam Road is a main arterial road in a growth area, where it may be that road infrastructure has not kept pace. While I understand that VicRoads has plans to duplicate Hallam Road in the future, no timeline was available as at the date of the view.
48. Moreover, there is a level crossing a short distance to the north of the Centre Road and Hallam Road intersection which is planned for removal. Paradoxically, removal of the level crossing may make matters more challenging for driver's intending to turn right into Hallam Road as the lowering of the boom gates and traffic control signals currently provide a limited window for right turns from Centre Road onto Hallam Road.

FINDINGS AND CONCLUSION

49. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - (a) the identity of the deceased was Mr AJ, born 21 February 1989;
 - (b) Mr AJ's death occurred on 6 June 2019 on Hallam Road, Hampton Park, between Centre Road and Blackwood Road;
 - (c) Mr AJ died from traumatic haemothorax sustained in a motorbike collision; and
 - (d) the death occurred in the circumstances described above.

RECOMMENDATIONS

50. Pursuant to section 72(2) of the Act, I make the following recommendations:
 - (a) In the interest of promoting public safety and preventing like deaths, pending the duplication of Hallam Road, I recommend that VicRoads and the Casey City Council review the circumstances of Mr AJ's death and consider the need for interim remediation of road infrastructure in the vicinity of the collision by:
 - (i) facilitating right turns from Centre Road onto Hallam Road whether by the installation of traffic controls signals or otherwise; or
 - (ii) converting the broken white dividing line to a single unbroken white line, thus prohibiting U-turns altogether; or
 - (iii) by signage or other means, encouraging drivers intending to turn right from Centre Road onto Hallam Road, to use existing traffic-signal controlled intersections

such as the intersection of Hallam Road and Pound Road, to safely negotiate a route north.

51. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

- (a) Ms AA, Senior Next of Kin
- (b) Karen MacDonald, VicRoads
- (c) The Proper Officer, Casey City Council
- (d) Clare Rowan, Transport Accident Commission
- (e) Leading Senior Constable John Diamond, Coroner's Investigator

Signature:



Paresa Antoniadis Spanos

Coroner

Date: 17 December 2020

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
