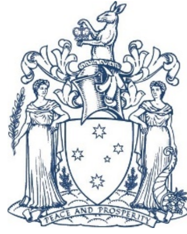

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003968

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Robert John Woolcock
Date of birth:	30 March 1965
Date of death:	11 August 2018
Cause of death:	1(a) Right ventricular tear due to blunt chest trauma sustained in a motor vehicle incident
Place of death:	Mildura Base Public Hospital, 216 Ontario Avenue, Mildura, Victoria, 3500

INTRODUCTION

1. Robert John Woolcock was 53 years old at the time of his death. He resided in Mildura with his de-facto partner, Donna Therese Fitzpatrick and her two adult children from a previous relationship. He also had a dog named D9.

2. On 11 August 2018, Mr Woolcock died at Mildura Base Public Hospital ("Mildura Hospital") following the injuries he sustained in a motor vehicle collision at the intersection of Etiwanda Avenue and Seventeenth Street ("the intersection") in Mildura.

THE CORONIAL INVESTIGATION

3. Mr Woolcock'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.

4. 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.

5. 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.

6. Victoria Police assigned Leading Senior Constable Anthony Johns (LSC Johns) to be the Coroner's Investigator for the investigation of Mr Woolcock's death. LSC Johns 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.

7. This finding draws on the totality of the coronial investigation into the death of Robert John Woolcock 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

Circumstances in which the death occurred

8. On 11 August 2018, at approximately 1.35pm, Mr Woolcock drove Ms Fitzpatrick's blue Mitsubishi Lancer sedan from Target located at Fifteenth Street in Mildura where he purchased a mixer, towards his home at Etiwanda Avenue in Mildura. He was travelling south along Etiwanda Avenue with his dog seated at the passenger seat towards the intersection.

9. At about the same time, Brendan Webb was travelling west along Seventeenth Street in his silver Mitsubishi Pajero with his wife and two children. Mr Webb recalled he was driving up to about 95 kilometres an hour ("**km/h**") while travelling from the south side of Seventeenth Street towards the intersection.

10. Mr Webb looked right and sighted Mr Woolcock's blue Lancer approaching the intersection when approaching the intersection. He did not attempt to stop as he sighted a dotted line on the road from Mr Woolcock's direction as he anticipated Mr Woolcock would give way and stop.

11. Mr Woolcock failed to obey the "Give Way" signs and drove straight across the intersection.

12. Mr Webb's vehicle struck the front passenger door of the blue Lancer. Both vehicles travelled across the intersection then separated and came to rest on the nature strip at the south-west corner of the intersection.

13. Mr Webb and witnesses to the collision, including Carmen Bellini, a resident living at the corner immediately came to the aid of Mr Woolcock. Ms Bellini observed Mr Woolcock was slumped in the driver's seat with his seat belt on and had a laceration on top of his head. She stated that Mr Woolcock was conscious but was struggling to breathe and was not responding to her questions.

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[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.

14. A short time later, Mr Woolcock released his seat belt and in an attempt to extricate himself from his vehicle, fell out of the car door to the ground onto his hands and knees.

15. At 1.36pm, Ambulance Victoria arrived at the scene and Mr Woolcock was subsequently transport to the Mildura Hospital.

16. At 2.04pm, Mr Woolcock was admitted to the Emergency Department (**ED**) of Mildura Hospital. Medical professionals gave Mr Woolcock an admission diagnosis that included blunt chest and head trauma. He suffered a cardiac arrest while medical staff were attempting to administer oxygen and obtain intravenous access. A mobile chest x-ray was obtained and showed pulmonary contusions.

17. Subsequently, Dr Rotimi Afolabi performed bilateral chest tube thoracotomies. Mr Woolcock remained hypotensive despite resuscitation and transfusion efforts. Ionotropic support was instituted.

18. Mr Woolcock suffered another cardiac arrest while being transferred to the operating theatre and he was again resuscitated.

19. During the surgery, Mr Woolcock's myocardium was noted to be very friable and was tearing under sutures which required reinforcement with the use of prosthetic vascular grafts. Mr Woolcock suffered ventricular fibrillation while the surgeons were attempting to insert vascular grafts. Multiple shocks, manual cardiac and multiple intra-cardiac adrenaline injections were administered. Mr Woolcock remained in ventricular asystole and was pronounced deceased at 3.51pm.

Police investigation

20. Upon attending the site of the collision, Victoria Police officers ascertained the road surface condition was good and dry despite light shower moments prior to the collision. The visibility was good. There was no evidence of braking prior to the collision and indication of excessive speed. The positioning of the blue Lancer and silver Pajero post collision and the extent of damage on both vehicles were consistent with the speed as alleged by Mr Webb.

21. Police conducted a preliminary breath test upon Mr Webb which returned a negative test. No charges have been laid against Mr Webb in relation the collision.

22. Investigations revealed evidence that Mr Woolcock was wearing seat belt at the time of the collision and the vehicle airbag fitted to drivers' side did not deploy due to the passenger's

side impact. Aside from the extensive damage of the vehicle sustained during the collision, Mr Woolcock's blue Lancer appeared in good condition. Subsequent inspection also did not identify any obvious faults that would have contributed to the collision.

23. During the course of investigation, LSC John also learned that Mr Woolcock previously held a full driver's licence issued in South Australia. It was noted however, Mr Woolcock was not licensed at the time of the collision. He had lost his drivers' licence on 2 July 2013 and had not made attempts to apply for a new licence. Mr Woolcock also had Victorian traffic convictions of exceeding speed limit on three occasions and driving with prescribed concentration of drug in the system.

24. Ms Fitzpatrick stated she was aware of Mr Woolcock's occasional unlicensed driving, but she described that Mr Woolcock "*had his moments*". Ms Fitzpatrick ruled out the possibility of mobile phone distraction and distraction by his dog D9.

25. LSC Johns also ruled out the environment unfamiliarity as Mr Woolcock had lived for several years and travelled through the intersection on numerous occasions, both as a passenger and a driver. LSC Johns, however, stated that it cannot exclude the possibility that Mr Woolcock's dog, seated in the passenger seat, may have caused a momentary distraction or obscured Mr Woolcock's view while he was approaching the intersection.

26. Etiwanda Avenue is a single carriageway road that has provision for one north bound and one south bound lane. The speed limit of Etiwanda Avenue leading to the north side of Seventeenth Street is set at 80km/h whereas the speed limit leading to the south side is default at 100km/h.

27. Seventeenth Street is also a single carriageway road that has provision for one north bound and one south bound lane. The total width of Seventeenth Street is measured at approximately 11.3 metres wide and broadens to 14.2 metres at the part leading to the north side of Etiwanda Avenue and broadens further to 31 metres at the intersection.

28. Along the south of Etiwanda Avenue, there are two category B size "Give Way" signs. One being erected at the side of the south bound lane at approximately 173.4 metres leading to Seventeen Street and another erected on the traffic island at the end of the Etiwanda Avenue leading the intersection. There is also a speed limit sign of 80 km/h erected at the section of Etiwanda Avenue leading to Seventeenth Street.

29. There are traffic islands in Etiwanda Avenue situated on both the north and south sides of Seventeenth Street. LSC Johns explained that the islands are positioned 'offset' to minimise the opportunity for vehicles travelling straight through the intersection without slowing.

30. LSC Johns noted there were vineyards on the east and west sides of Etiwanda Avenue, with grape vines on the east side planted on a lower trellis than the west side. He advised the view to the east approaching the intersection was good in comparison to the west, considering there was no vine foliage,

Identity of the deceased

31. On 11 August 2018, Robert John Woolcock, born 30 March 1965, was visually identified by his partner, Donna Therese Fitzpatrick. Identity is not in dispute and requires no further investigation.

Medical cause of death

32. On 15 August 2018, Forensic Pathologist Dr Yeliena Fay Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on the body of Mr Woolcock. Prior to the autopsy, Dr Baber reviewed a post-mortem computed tomography (**CT**) scan and E-Medical Deposition form and referred to the Victoria Police Report of Death (Form 83). Dr Baber also reviewed the toxicology report after the autopsy and provided a written report of her findings dated 8 October 2018.

33. Dr Baber commented that the mechanism of death was due to blood loss from a laceration in the right ventricle which was caused by one of the displaced left sided rib fractures penetrating the heart, resulting in a ragged laceration. The left hemidiaphragm has been similarly lacerated with associated injury to the spleen and injury to the left lung lower lobe.

34. Toxicological analysis of ante-mortem samples identified the presence of methylamphetamine (~2.0mg/L) and amphetamine[2] (~0.2mg/L). No ethanol (alcohol) was detected.

35. Dr Baber provided an opinion that the medical cause of death was 1 (a) right ventricular tear due to blunt chest trauma sustained in a motor vehicle incident.

[2] Amphetamines is a collective word to describe central nervous system (**CNS**) stimulants structurally related to dexamphetamine. One of these, methylamphetamine, is often known as "speed" or "ice". Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline.

FURTHER INVESTIGATIONS

36. On 15 August 2018, LSC Johns, Highway Patrol Sergeant Mark McDonald and representatives from the Department of Transport (**DOT**) and Mildura Rural City Council (**MRCC**) attended the collision scene. They assessed the roads leading to the intersection and made recommendations on improving the safety of the sections of Etiwanda Avenue and Seventeenth Street leading to the intersection.

37. During the assessment, the representatives revealed that the Mildura truck bypass plan involving several roads intersections would include an installation of a roundabout at the intersection of Seventeenth Street and Etiwanda Avenue.

38. By way of letter dated 24 August 2020, Daryl Morgan, manager of Works and Engineering Services of the MRCC advised the Court that MRCC has taken actions to realise the proposed recommendations after the assessment. The category "B" size Give Way signs[3] have been replaced with larger category "C" size signs to create a greater visual presence to road users approaching the intersection.

39. In relation to the Mildura truck bypass plan, the MRCC advised that it is still lobbying for the plan's creation and remained unfunded at the time of its response to the Court.

40. Mr Morgan advised that MRCC has started the process of lowering the speed limit of Seventeenth Street to 80 km/h and collaborated with Regional Roads Victoria (**RRV**) to have the speed limit of the roads leading to Seventeenth Street lowered from 100km/h to 80km/h to ensure a greater compliance with the new 80km/h speed limit.

41. The category "B" size Give Way signs have been replaced with larger category 'C' size signs, to create a greater visual presence to road users approaching the intersection.

42. Oversized bi-directional road signs[4] have been installed in Etiwanda Avenue to lessen the "see-through effect'" caused by the intersection being offset and looking like a traditional intersection.

[3] See paragraph 27.

[4] Also known as chevron road signs.

43. The MRCC also advised that in order to meet the Black Spot Program[5] guidelines, MRCC is investigating in:

   a) Creating a joint application to include the intersection to demonstrate that the intersection is a precinct instead of an individual site[6];

   b) Innovating a new compact roundabout design[7];

   c) Installing traffic lights; and

   d) Installing of side road activated speed limits on Seventeenth Street, which would lower the speed limit to 60km/h on Seventeenth Street for vehicles approaching Etiwanda Avenue.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

44. I note and commend in particular the initiatives taken by my Coroner Investigator, LSC McCormick with regards to the opinions he expressed about the apparent risks associated with the intersection and together with representatives of VicRoads and MRCC, took part in improving the safety of the intersection.

45. I also note that MRCC has taken restorative and prevention actions to resolve the risks associated with the intersection after Mr Woolcock's death. I also commend the effort of MRCC for implementing the improvement as discussed above and they have taken further steps to ensure compliance with the improvements.

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[5] The Black Spot Program was introduced as part of the Australian Government's commitment to reduce crashes on Australian roads. It directly targets roads with a proven crash history or locations identified as high-risk. Funding for the program is mainly focused on the most cost-effective treatment of hazardous road locations.

[6] The Black Spot Program funding is mainly available for treatment of Black Spot sites with a proven history of crashes. For individual sites such as intersections, there should be a history of at least three casualty crashes over a five-year period. See Department of Infrastructure, Transport, Regional Development and Communications, *Site Eligibility*, last updated 26 August 2021.

[7] The MRCC explained the crash reduction factor to install a traditional roundabout is not financially viable to meet the Black Spot Program's guidelines.

RECOMMENDATIONS

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

46. With the aim of promoting public health and safety and preventing like deaths, I recommend that MRCC continue to examine the traffic patterns and monitor traffic count data at the intersection of Etiwanda Avenue and Seventeenth Street in Mildura to determine whether the intersection is a location that could be considered under the Black Spot Program as a site that has a recurrent problem.

FINDINGS AND CONCLUSION

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Robert John Woolcock, born 30 March 1965;

    b) the death occurred on 11 August 2018 at Mildura Base Public Hospital, 216 Ontario Avenue, Mildura, Victoria, 3500;

    c) I accept and adopt the opinion ascribed by Dr Yeliena Fay Baber as to the medical cause of Robert John Woolcock's death and I find that Robert John Woolcock died from right ventricular tear arising from a blunt chest trauma sustained in a motor vehicle incident, in the circumstances where he failed to give way and crossed the intersection of Seventeenth Street and Etiwanda Avenue; and

    d) I further find that Robert John Woolcock's illicit drug use cannot be excluded as having possibly contributed to his driving behaviour including entering a signed intersection without stopping or giving way as he was required by law.

48. Having considered all the evidence, I am satisfied that the weight of the evidence supports a finding that Robert John Woolcock caused the collision which led to his own death.

I convey my sincere condolences to Mr Woolcock's family for their loss.

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:

Donna Fitzpatrick, Senior Next of Kin

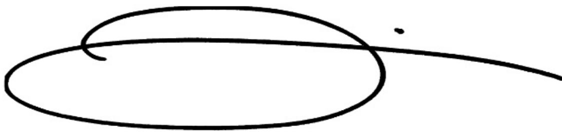
Leading Senior Constable Anthony Johns, Coroner's Investigator

Mildura Base Hospital

Mildura Rural City Council

VicRoads

Signature:



AUDREY JAMIESON

CORONER

Date: 8 December 2021

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.