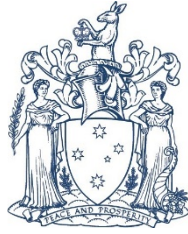

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001302

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Khaled El Rafihi
Date of birth:	18 September 1998
Date of death:	13 March 2019
Cause of death:	1(a) Head injury
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052
Keywords:	Motor vehicle accident, single vehicle, ute surfing, car surfing

INTRODUCTION

1. Khaled El Rafihi was 20 years of age at the time of his death. He was an apprentice electrician and lived with his family in Campbellfield.

2. Khaled died from head injuries at Royal Melbourne Hospital following a "ute surfing" incident that occurred three days earlier.

THE CORONIAL INVESTIGATION

Jurisdiction

3. Khaled's death was reported death under section 4 of the *Coroners Act 2008* ("the Act"), because it occurred in Victoria, and was considered unexpected, unnatural and resulted from an accident.

Purpose of a coronial investigation

4. The Coroners Court of Victoria is an inquisitorial jurisdiction[1]. Coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. The role of the coroner is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners should also liaise with other investigative bodies to avoid unnecessary duplication and expedite the investigation.[2]

5. The specific purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of a deceased person, medical cause of death, and circumstances in which the death occurred. Circumstances surrounding the death are limited to events which are sufficiently proximate and causally related to the death.

6. The broader purpose of coronial investigations is to contribute to a reduction in number of preventable deaths. In exercising their statutory obligations, Coroners are empowered to make comments or recommendations in appropriate cases about any matter connected to the death they have investigated, including matters of public health or safety and the administration of justice.

[1] Section 89(4) of the *Coroners Act 2008* (Vic) ("the Act").
[2] Section 7 of the Act.

Conduct of my investigation

7. As part of the coronial investigation, advice was sought from the Coroners Prevention Unit[3] (**CPU**), for the purposes of identifying any like incidents and examining possible prevention opportunities in this matter with a view to making recommendations if appropriate.

Sources of evidence

8. This finding draws on the entirety of the investigation material[4] comprising of the coronial Brief of Evidence compiled by Sergeant Brendan Eames-Mayer[5] ("Sgt Eames-Mayer"), including material obtained after the provision of the brief and the statements of witnesses.

Standard of proof

9. 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.[6]

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

Circumstances in which the death occurred

10. On 10 March 2019, Khaled's cousin Bilal El-Rafei drove his 2007 white Holden Commodore coupé utility[7] to his home at Carlisle Court, Campbellfield and spent the afternoon with Khaled and his brother, Fadel. At approximately 6.02pm, they left the house in the Holden utility, with Bilal driving the vehicle. As a coupé model utility is a two-seater vehicle, Fadel was seated in the only passenger's seat and Khaled was seated at the rear on the flat boot lid.

11. Shortly after they left the house, Bilal turned left to the southbound lane of Cambridge Way. The surveillance footage from a neighbourhood Closed-Circuit Television (**CCTV**) located on Cambridge Way depicted that the Holden utility travelled at speed. Khaled, who appeared

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[3] The Coroners Prevention Unit (**CPU**) assists the coroner with research in matters related to public health and safety in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

[4] Which also included photos, video material and maps.

[5] He was a Detective Leading Senior Constable at the time of the investigation. I will refer to him as his current rank throughout the Finding.

[6] 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.

[7] Colloquially known as a "ute".

to be sitting at the rear edge of the boot lid, pitched forward and fell onto the road and hit his head.[8]

12. Bilal immediately turned around and stopped his vehicle and contacted emergency services. Ambulance Victoria paramedics subsequently attended and transferred Khaled to the Royal Melbourne Hospital.

13. At the hospital, Khaled underwent a computed tomography (**CT**) scan which showed intracranial haemorrhage, which was deemed nonsurvivable by neurosurgical physicians. He was declared deceased at 3.42pm on 13 March 2019.[9]

Identity of the deceased

14. On 13 March 2019, Khaled El Rafihi, born 18 September 1998, was visually identified by his mother, Sahar El Rafihi.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. On 15 March 2019, Forensic Pathologist Dr David Leo Ranson from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on the body of Khaled El Rafihi. Dr Ranson also reviewed the post-mortem CT scan and referred to the Victoria Police Report of Death (Form 83). Dr Ranson provided a written report of his findings dated 19 March 2019.

17. The post-mortem examination CT scan revealed a fractured to the back of the occiput in the midline and extending over the left side of the skull. There was evidence of right subdural haemorrhage, diffuse anterior subarachnoid and haemorrhage and contusions.

18. Toxicological analysis of ante-mortem samples identified the presence of morphine, midazolam, atropine, paracetamol and ketamine.

19. Forensic toxicologist, Elizabeth Gould-Williams noted the possibility that the drugs detected were administered as part of intensive care treatment. I accept, on the balance of probabilities

[8] CB, Exhibit: Surveillance footage.
[9] Court File (**CF**), E-Medical Disposition Form.

that the abovementioned drugs were administered during resuscitation and intensive care treatment and were not causally or casually linked to Khaled's death.

20. Dr Ranson ascribed the medical cause of death to 1 (a) head injury.

Police investigation

21. Immediately following the incident, Victoria Police officers, including Senior Constable Samuel Field ("SC Field") attended the scene at Cambridge Way and commenced an investigation. They ascertained that the roadway was dry, the weather was fine, and the visibility was good. The road was sealed and the surface was in good condition. The speed limit is set at 50km/h.

22. SC Field conducted a preliminary oral fluid test upon Bilal at the scene which returned a negative result. A drug and alcohol analysis of his blood sample conducted later at Northern Hospital also returned negative.

23. Bilal was arrested and conveyed to Broadmeadows Police Station for an interview. He made a "no comment" record of interview and was released the same night of the incident.

24. On 14 March 2019, Sgt Eames-Mayer of Victoria Police Major Collision Investigation Unit **(MCIU)** was notified of the fatal incident and advised that MCIU would take carriage of the investigation. On the same day, he attended the scene at Cambridge Way.

25. During the course of the investigation, Sgt Eames-Mayer executed a search warrant on a Cambridge Way property outside which the incident occurred and seized a CCTV surveillance system hard drive. The surveillance footage showed Khaled falling from the Holden utility onto the road.[10]

26. The Holden utility was impounded for mechanical inspection. On 4 July 2020, Senior Constable Raymond Finch inspected the vehicle and noted the rear tyres were in poor condition and "partially bald". He also observed the driver's seat belt was wrapped around the headrest and buckled, allowing the driver to drive unrestrained without warning alarms sounding. The inspection did not reveal any mechanical fault which would have caused or contributed to the incident.[11]

[10] CB, Exhibit: Surveillance footage.
[11] CB, page 55.

27. Collision Reconstruction Expert Detective Senior Constable Melanie MacFarlane conducted an analysis of the reconstruction of the event and determined that the Holden utility was travelling at a speed of between 35 and 42km/h prior to the incident.

Subsequent criminal proceedings

28. As a result of the incident on 10 March 2019, Bilal was charged with dangerous driving causing death[12] (charge 1) as well as two summary offences relating to failing to wear a seatbelt[13] (charge 2) and using a motor vehicle in an unsafe and not roadworthy condition[14] (charge 3).

29. Following a Committal Mention hearing in March 2021 at Melbourne Magistrates Court, the presiding Magistrate ordered that Bilal be committed to trial at the County Court of Victoria in early 2022.

30. On 9 December 2021, the Director of Public Prosecutions (**DPP**) filed a *Notice of Related Summary Offence* at the County Court and indicated the prosecution's intention to withdraw charge 2 and 3.

31. On 10 December 2021, the DPP entered a *nolle prosequi* to the County Court of Victoria to discontinue the prosecution of charge 1.[15]

CPU REVIEW

32. As part of its review, the CPU interrogated the Court's surveillance database[16] and the National Coronial Information System **(NCIS)**.[17] Specifically, the CPU analysed deaths reported to an Australian coroner between 1 January 2013 and 23 February 2023, where the evidence indicated the deceased was engaged in "ute surfing" at the time of the fatal incident.

33. The CPU identified 27 deaths between 2013 and 2023, including Khaled's, that occurred in the context of ute surfing. The CPU noted these fatalities were uncommon, given the statistical figure. Eleven of the deaths occurred in Victoria, and deaths amongst males under the age of 40 were most common.[18]

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[12] In contravention of section 319(1) of the Crimes Act 1958 (Vic).
[13] In contravention of regulation 264 of the Road Safety Rules 2017 (Vic).
[14] In contravention of regulation 259 of the Road Safety (Vehicle) Regulations 2009 (Vic).
[15] CF, Notice of Discontinuance.
[16] The surveillance database contains information on all Victorian deaths reported to the coroner since 1 January 2000.
[17] The NCIS includes data on all deaths reported to an Australian coroner since 1 July 2000.
[18] 24 of those killed were male, with 22 being under the age of 40 years.

34. The CPU identified a range of circumstances in which the above-mentioned deaths occurred. 13 deaths, including that of Khaled, occurred while the deceased was riding in the tray of the ute primarily for enjoyment. Other deaths occurred in circumstances such as hunting on rural properties, carrying out farm work, and climbing into the tray of the ute to retrieve items while the vehicle was moving.

35. In 14 instances, including this matter, the driver of the vehicle of the vehicle was charged with an indictable offence.

COMMENTS

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

1. I left my coronial investigation in abeyance while I awaited the outcome of the criminal prosecution against Bilal El-Rafei. Following the conclusion of the criminal proceedings against Bilal, I resumed my investigation with a restorative and preventative viewpoint.

2. While I am mindful that the circumstances in which Khaled's death have been addressed by criminal proceedings against Bilal, I deemed there is a public interest in the incident and a need to highlight vehicle occupant safety issues, particularly to young persons.

3. In doing so, it is appropriate for me to make a Finding regarding the circumstances surrounding Khaled's death.[19] It is also appropriate for me to make comments on road safety issues connected with Khaled's death as these issues concern public health and safety.[20]

4. As foreshadowed in the introduction, Khaled died in an incident of "ute surfing". Ute or car surfing has been described by the New South Wales (NSW) Parliament road safety committee (STAYSAFE Committee) in its 2004 Final Committee Report to the Parliament of NSW, as *a "dangerous activity of passengers sitting or standing on moving cars and utes as though they were 'surfing'"*.[21] Importantly, the STAYSAFE Committee highlights that *"the recklessness and dangerousness of such actions arises from the lack of occupant restraint devices to keep these persons on the vehicle, and the lack of protective clothing, such as helmets, that would minimise injury if these persons fell from the vehicle"*.[22]

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[19] Section 8(f) and 67(1) of the Act.
[20] Section 67(3) of the Act.
[21] Parliament of New South Wales STAYSAFE Committee, *Report on car surfing and the carriage of unrestrained and unprotected passengers on motor vehicles* No. 2/53 (2004) p. vii.
[22] Ibid.

5. It is incredibly disappointing to note that despite ute and car surfing being such an inherently dangerous and illegal activity, lives continue to be lost. I would remind Victorians that ute surfing remains illegal and can have lasting and fatal consequences for those who choose to engage in it.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Khaled El Rafihi, born 18 September 1998;

   b) the death occurred on 13 March 2019 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052;

   c) I accept and adopt the medical cause of death ascribed by Dr David Leo Ranson and I find Khaled El Rafihi died from head injuries in circumstances that were preventable.

   d) AND, ultimately, it is a tragedy that a young life has been lost due to Khaled El Rafihi's decision to sit on the hard lid of Bilal El-Rafei's ute tray while the vehicle was moving. His actions, and those of his cousin, placed him at great risk of injury or death. That Khaled El Rafihi lost his life is the direct and tragic result of his decision to ute surf.

I convey my sincere condolences to Khaled'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:

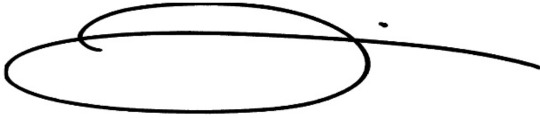
Sahar El Rafihi, Senior Next of Kin

Rabi El Rafei, Senior Next of Kin

Sergeant Brendan Eames-Mayer, Coroner's Investigator

Transport Accident Commission

Signature:



AUDREY JAMIESON

CORONER

Date: 20 MARCH 2023

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.