IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 005952

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr J [1]
Date of birth:	[redacted] 1955
Date of death:	29 October 2019
Cause of death:	*Injuries sustained in a motor bike and motor vehicle collision (motor bike rider)*
Place of death:	Calder Alternative Highway, Marong, Victoria

1. This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased and his family members with pseudonyms to protect their identity and redact identifying information

INTRODUCTION

1. On 29 October 2019, [redacted] (**Mr J**) was 64 years old when he died in a collision with a motor vehicle while driving his 2009 Harley Davidson FLHX (**the motorcycle**). Mr J was an experienced motorcycle rider and was the Road Leader of the [redacted] of the American Motorcycle Club.

2. At the time of his passing, Mr J lived in [redacted], Victoria, where he worked full-time on his farm and was a respected member of his local community. He was the Deputy Group Officer for the local Country Fire Authority, and Chairman of the [redacted] Committee. He is survived by his children [redacted], [redacted] and [redacted], and stepchildren [redacted] and [redacted]

THE CORONIAL INVESTIGATION

3. Mr J'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 Sergeant Peter Romanis (**Sgt Romanis**) to be the Coroner's Investigator for the investigation of Mr J's death. Sgt Romanis 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 Mr J 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 28 October 2019, [redacted] spoke to his father who advised he had been on a ride with his motorcycle club to an event in Newcastle. Mr J reported that he had just ridden from Armidale to Narrandera, where he would stop for the night. [redacted] states that his father was in good spirits and planned the following day to arrive back at the farm at lunchtime so that they could go about some business together.

9. On 29 October 2019, [redacted] (**Mr T**) was working for Pure Peninsula Honey collecting beehives in the Marong area. Mr T held an unrestricted Heavy Rigid New South Wales driver's licence and was driving a 2004 Iveco Eurotech Rigid Tray Truck (**the Iveco**) with his colleague [redacted] (**Mr S**) in the passenger seat.

10. At approximately 11.00am, Mr T and Mr S met up with a second truck driven by [redacted] (**Mr H**) to load pallets of honey and bees onto the back of the Iveco. After having loaded the Iveco, Mr T followed Mr H along the Calder Alternative Highway to the intersection with Bullock Road.

11. Mr H completed a right turn into Bullock Road and Mr T followed in the Iveco. At the same time, Mr J was riding his motorcycle south on the Calder Alternative Highway towards the intersection.

12. Witnesses reported that the motorcycle collided head on with the front of the Iveco. Mr S called triple zero immediately and commenced cardiopulmonary resuscitation (**CPR**) under instruction from the call taker.

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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.

13. Victoria Police officers and Ambulance Victoria paramedics arrived at the scene soon after. Sadly, resuscitation attempts were unsuccessful and Mr J was pronounced deceased at the scene.

Collision reconstruction

14. Detective Sergeant Robert Hay (**DS Hay**) of the Victoria Police Major Collision Investigation Unit conducted an investigation and completed a forensic collision reconstruction. DS Hay opined:

> *When the Iveco was removed a short pre-impact tyre scuff mark was observed from the front passenger tyre of the Iveco. This would indicate emergency braking was applied just prior to the impact…*
>
> *…It is clear the Iveco was moving at a low speed as it began to turn into Bullock Road. This is evident by the short stopping distance…*
>
> *…There was no evidence of pre-impact braking from the motorcycle in the form of tyre marks on the road surface… It is not possible to determine the speed of the Harley Davidson at the time of the impact or at any time leading up to the impact.*

Criminal prosecution

15. Mr T was charged with offences under section 65 of the *Road Safety Act 1986* (Vic) and section 319 of the *Crimes Act 1958* (Vic) arising from the incident. At trial, the jury found Mr T not guilty of dangerous driving causing death. He entered a plea of guilt in relation to the charge of careless driving and was found guilty without conviction and fined $1000.00.

Identity of the deceased

16. On 7 November 2019, Mr J, born [redacted] 1955, was identified by scientific analysis.

17. Identity was not in dispute and required no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an examination on 1 November 2019 and provided a written report of her findings dated 7 November 2019.

19. The post-mortem examination showed injuries consistent with the reported circumstances.

20. Toxicological analysis of post-mortem samples did not detect ethanol (alcohol) or any other common drugs or poisons.

21. Dr Francis provided an opinion that the medical cause of death was *injuries sustained in a motor bike and motor vehicle collision (motor bike rider)*.

22. I accept Dr Francis' opinion as to medical cause of death.

FINDINGS

23. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Mr J, born [redacted] 1955;

    b) the death occurred on 29 October 2019 at Calder Alternative Highway, Marong, Victoria, from *injuries sustained in a motor bike and motor vehicle collision (motor bike rider)*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATIONS

24. During the coronial investigation, I provided the Victorian Department of Transport (**DOT**) an opportunity to make submissions in response to recommendations I proposed to make in this matter. The DOT provided helpful submissions on a proposed recommendation that the speed limit be reduced to 80 km/hr along Calder Alternative Highway between Bullock Road and Boyles Lane. The DOT advised that it conducted a speed zone assessment in this area on 18 November 2022, which resulted in the speed limit being reduced to 80km/hr on either side of the roundabout at Maryborough Road, Lockwood. I am satisfied that these changes, in combination with the below recommended improvements, will increase driver vigilance and road safety in the area.

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

    a) That the Victorian Department of Transport install signage on the approach to both Bullock Road intersections on the Calder Alternative Highway to indicate ‘Concealed Road’; and

    b) That the Victorian Department of Transport install signage on Bullock Road at its intersection with Calder Alterative Highway to indicate ‘Beware of Turning Vehicles’.

OTHER MATTERS

26. I convey my sincere condolences to Mr J’s family, friends, and community for their loss, and I acknowledge the sudden and traumatic circumstances in which his death occurred.

27. 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.

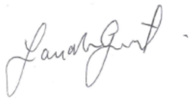
28. I direct that a copy of this finding be provided to the following:

    a) [redacted], Senior Next of Kin

    b) Secretary, Victorian Department of Transport

    c) Sergeant Peter Romanis, Coroner’s Investigator

Signature:



Coroner Sarah Gebert

Date : 24 May 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.