IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006818

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Sarah Catherine Tonkin
Date of birth:	3 November 1982
Date of death:	13 December 2019
Cause of death:	1(a) Blunt force head injuries
Place of death:	Bacchus Marsh-Geelong Road, Balliang, Victoria, 3340

INTRODUCTION

1. On 13 December 2019, Sarah Catherine Tonkin was 37 years old when she died in a motor vehicle incident. At the time of her death, Sarah lived in Jan Juc with her husband, Gregor and their eight-month-old son, Austin.

THE CORONIAL INVESTIGATION

2. Sarah'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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Sarah'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.

6. This finding draws on the totality of the coronial investigation into the death of Sarah Catherine Tonkin 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]

[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.

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

Circumstances in which the death occurred

7. At approximately 2:18pm on 13 December 2019, Sarah was driving her Hyundai Tucson SUV ("the Hyundai") from her aunt's funeral in Bacchus Marsh to her home in Jan Juc. Sarah was travelling with Austin who was appropriately secured in a child seat in the rear passenger seat of the Hyundai.

8. Sarah was travelling in the south-west bound lane of Geelong-Bacchus Marsh Road. A Kenworth B Double Heavy Vehicle ("the B Double") was travelling in the opposite lane in a north-east direction. The driver of the B Double noticed an object laying on the road, which had been driven over by the vehicle in front. The B Double drove over the object, a large steel tow hitch assembly ("tow hitch"), and in doing so caused the tow hitch to 'flick up' from the road, directly into the path of Sarah's vehicle.[2] According to the driver of the B Double, he drove directly over the tow hitch and does not believe he hit it with the truck's wheels.

9. The tow hitch struck the driver's side bonnet of the Hyundai before penetrating the windscreen and striking Sarah in the right side of her head, leaving her unable to control the Hyundai. The Hyundai drifted to the left, across the shoulder of the road and onto a grassed area where it struck and uprooted a medium sized gumtree, the impact of which caused the Hyundai to roll over onto the driver's side. Witnesses immediately stopped to assist and called emergency services.[3]

10. Shortly thereafter Ambulance Victoria paramedics arrived at the scene, though tragically Sarah was unable to be revived.[4]

11. At the time of the incident, how the tow hitch came to be on the road was unknown.

Identity of the deceased

12. On 20 December 2019, Dr Lyndall Smythe from the Victorian Institute of Forensic Medicine (**VIFM**) compared the DNA of the deceased with a sample from the neonatal screening card of the baby of Sarah's mother, Pauline Tonkin.

[2] CB, Statement of EG, dated 13 December 2019.
[3] Ibid.
[4] CF, Ambulance Victoria Patient Care Record.

13. Dr Smythe provided a report which confirmed that the DNA profile of the baby of Pauline Tonkin had the same DNA profile as the deceased.

14. My colleague, Coroner Sarah Gebert, reviewed the available evidence including the DNA report of Dr Smythe and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was Sarah Catherine Tonkin, born 3 November 1982. Accordingly, she signed a Determination by Coroner of Identity of Deceased (Form 8), dated 20 December 2019.

Medical cause of death

15. Forensic Pathologist Dr Joanna Moira Glengarry from the VIFM conducted an external examination on the body of Sarah Tonkin on 16 December 2019. Dr Glengarry reviewed the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of her findings dated 20 December 2019.

16. The post-mortem examination revealed severe injuries in keeping with the reported circumstances of the death. Dr Glengarry noted that the injuries were 'more than sufficient to have resulted in [Sarah's] death at the scene of the incident'.

17. Toxicological analysis of post mortem samples did not identify the presence of alcohol or any commons drugs or poisons.[5]

18. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) BLUNT FORCE HEAD INJURIES.

VICTORIA POLICE INVESTIGATION

Preliminary Investigation

19. At approximately 5:20pm on 13 December 2019, Detectives from the Victoria Police Major Collision Investigation Unit (**MCIU**) attended at the scene having been alerted to the incident by the Moorabool Highway Patrol.[6]

20. Detectives noted that on the day of the incident, the road surface was in good condition and the conditions were fine – the weather was fine, the road was dry, and visibility was good.[7]

[5] Court File (**CF**), Toxicology Report of Jared Castle, Forensic Toxicologist, dated 2 January 2020.
[6] CB, Statement of Detective Sergeant Philip Frith, dated 21 August 2023.
[7] Ibid.

21. Initial examinations of the road surface suggested that the tow hitch had likely dislodged and fallen from the towbar of a vehicle travelling north-east. The tow hitch appeared to be new, with no wear or markings on the tow ball and no visible wear within the bore that the hitch pin would go through to secure the tow hitch to the vehicle. Detectives searched the area and located a black plastic towbar receiver surround which appeared relatively new and was printed with the name 'BTA TOWBARS'.

22. For context, the tow hitch assembly involved in this incident was a 'combination pintle hook' assembly comprised of two individual components – a pintle hook adaptor plate and a pintle hook assembly – bolted together. The tow hitch assembly had a 50mm square section inserted into a similar sized receiver in a vehicle's tow bar. The hitch is secured within the towbar by a 15mm diameter steel 'hitch pin' that is inserted through one side of the towbar, passes through the hitch assembly, and exits on the other side of the towbar. The hitch pin is secured by a spring steel 'R clip' which passes through a hole in the hitch pin.

23. Detectives conducted enquiries within the automotive industry which led them to believe that the tow hitch had come from either a large four-wheel drive, or a small to medium sized truck.

24. Victoria Police also called for public assistance via a media release. In response to this, detectives received dashcam footage from a south-west bound vehicle travelling past the scene shortly after the incident, and closed-circuit television (**CCTV**) footage from Balliang East Primary School, located on Geelong-Bacchus Marsh Road approximately 1.6 kilometres south-west of the incident site.

25. Detectives reviewing the CCTV identified the white Kenworth B Double truck, as well as a white Isuzu truck ("the Isuzu") travelling just over one minute ahead of the B Double. The Isuzu became the primary vehicle of interest.

26. Sarah's father, Richard, participated in a media conference again calling for the assistance of the public in identifying the vehicle. As a result of the media conference, detectives received information identifying the driver of the Isuzu.

Further investigation

27. On 18 December 2019, carriage of the investigation was transferred to the Victoria Police Heavy Vehicle Unit Criminal Investigation Unit (**HVU CIU**).

28. At the time of the incident, the Isuzu was being driven by Colin Durham in his capacity as an employee of Winter & Taylor, an Isuzu and Iveco dealer in Corio. Mr Durham was driving the Isuzu from the dealership in Corio to Sunbury for delivery to a new owner.[8]

29. A photograph taken of the Isuzu by another Winter & Taylor employee outside the dealership showed the tow hitch intact.[9] However, upon receipt of the vehicle, the new owner reported to the dealer that the tow hitch assembly and other items were missing.

30. On 19 December 2019, HVU CIU detectives attended at Winter & Taylor. The company supplied them with several documents in relation to the Isuzu and showed detectives a replacement tow hitch that had since been procured, which appeared to be an exact match to the tow hitch located at the scene of the incident.

31. Detectives determined the timeline of events involving the Isuzu was as follows:

    a) On 26 September 2019, the Isuzu was delivered to Winter & Taylor.

    b) On 1 October 2019, the Isuzu underwent a pre-delivery inspection.

    c) On or around 21 October 209, the Isuzu was taken to 600 Cranes to have foundation work conducted for the fitting of a hydraulic boom crane to the rear of the truck.

    d) On or about 13 November 2019, the Isuzu was transported to Brenmark Transport Equipment to have the rear tray and towbar fitted.

    e) On 18 and 19 November 2019, Brendan Prain of Prain Consulting inspected the Isuzu and issued a Vehicle Assessment Signatory Scene Approval Certificate[10] in relation to Brenmark Transport Equipment's work, which included the fitting of the tray, towbar, pintle hook and tow ball.

    f) The Isuzu was then returned to 600 Cranes, where the installation of the crane was completed.

    g) On 26 November 2019, Murray Phelps inspected the crane and issued a Vehicle Assessment Signatory Scene Approval Certificate.

[8] CB, Statement of Colin Durham, dated 2 January 2020.
[9] CB, Photograph 72.
[10] A Vehicle Assessment Signatory Scene Approval Certificate is required or vehicles that have been modified, imported or are individually constructed in order to ensure the vehicle is safe and compliant with any applicable standards.

h) On 28 November 2019, the Isuzu was returned to Winter & Taylor and a reverse camera was fitted above the tow hitch. The Isuzu was then parked in a yard accessible to the public, where Winter & Taylor had reported recent thefts.

i) On 12 or 13 December 2019, the Isuzu was washed and prepared for delivery. No inspection or documentation was made. According to Mr Durham, washing, detailing and pre-delivery checking is ordinarily performed by the Winter & Taylor sales department.

32. At around 12:45pm on 13 December 2019, Mr Durham drove from Winter & Taylor to Sunbury. Before leaving, he walked around the Isuzu and recalls that the towbar was on the vehicle.[11] Another employee, Lisa Taylor, was to follow Mr Durham so she could drive them back to Winter & Taylor. As they left the dealership, she took a photo of the rear of the Isuzu so that she had the license plate number for reference. Mr Durham travelled approximately 35 kilometres before the tow hitch became dislodged, though no one observed this occurring. According to Mr Durham, Ms Taylor travelled directly behind him the entire route.[12]

Installation of the tow hitch

33. HVU CIU investigators obtained documents and photographs regarding the work undertaken at Benchmark Transport Equipment and 600 Cranes. Photographs taken by Brendan Prain during his inspection on 19 November 2019 show the tow hitch in place, with a gold-coloured hitch pin clearly visible.

34. Mr Prain provided a statement in which he outlined his responsibilities which included conducting a physical inspection in relation to modifications of a vehicle, in this case the fitting of a rear tray body and tow bar. During his first inspection, the retaining bolts holding the pintle hook to the adaptor were in place but had not been tightened. At the second inspection, the hitch pin had been replaced with a different model, the bolts had been tightened and it was presumed that it was correctly installed. Mr Prain noted *if a bolt appears to have been tightened, it is not my role to check the tension of that bolt, as it has been installed and tightened by a technician who is assumed to be skilled in this area, it is presumed that it has been tensioned correctly.*[13]

[11] CB, Statement of Colin Durham, dated 2 January 2020.
[12] Ibid.
[13] CB, Statement of Brendan Prain, dated 9 May 2023.

35. Sergeant Philip Frith attended at Brenmark Transport and spoke to Brendan Makowitsch who declined to make a formal statement but advised that the hitch pin *would have been correctly installed when the truck left his premises, but did not expect the people who had worked on the truck to recall installing that particular pin, given the volume of trucks they have through the premises.*[14]

36. Following analysis of the evidence, and reconstruction of the tow hitch, investigators formed the belief that the hitch pin securing the towbar assembly was not properly installed at the time of Mr Prain's inspection on 19 November 2019, as it would not have been possible to fit the 'R' clip to secure the hitch pin in place with the hitch pin in the position that it was.

37. They were unable to establish whether the hitch pin was subsequently fitted correctly, though noted that the works undertaken to install the crane did not require the removal and re-installation of the tow hitch.

38. It was clear that the incident occurred due to the tow hitch not being properly secured in the towbar by the hitch pin. However, what remained unclear was whether the tow hitch was inadvertently installed incorrectly, or whether the hitch pin securing the tow hitch was removed by an unknown person whilst the Isuzu was parked at Winter & Taylor between 28 November and 13 December 2019.

39. Investigators noted that the tow hitch remained in place for approximately 145km of travel following its installation, though became dislodged only 35km into the trip from Winter & Taylor to Sunbury. However, owing to the design and weight of the tow hitch, it would have been held in place until the vibration and bouncing from travelling along rough roads allowed it to gradually move out of place. It would therefore be impossible to determine with any certainty how long this process would take to occur.

COMMENTS

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

1. Despite a thorough police investigation, it is still unclear how the tow hitch came to be on the road, causing this tragic incident and the loss of Sarah's life. It is also unclear exactly who was responsible for ensuring the tow hitch was installed correctly and safely. This lack of clarity makes it difficult to determine any prevention opportunities.

[14] CB, Statement of Detective Sergeant Philip Frith, dated 21 August 2023.

2. My Coroner's Investigator, Leading Senior Constable Jason Barry-Basset, identified a similar incident that occurred in South Australia on 27 January 2022, where a tow hitch, that should have been secured by the same style of hitch pin, fell from a Toyota Hilux utility vehicle whilst it was travelling on a freeway, colliding with the windscreen of the car directly behind it. Fortunately, no one was injured.

3. My Coroner's Investigator also helpfully suggested that the risk of this occurring could be significantly reduced if the hitch pin was attached by a flexible tether such as a chain of cable. Therefore, should the pin not be fitted, or should it fall out, it would remain attached to the towbar, hanging down, and would serve as a visual cue for action to be taken.

4. I intend to distribute this finding to both VicRoads and the National Heavy Vehicle Regulator and encourage them to review the circumstances of Sarah Tonkin's tragic death in considering whether there are any possible changes that could be made industry regulations, guidelines, or checklists with the aim of a) ensuring the correct installation of tow hitch assemblies and b) ensuring that the tow hitch assembly is checked by vehicle assessors following the modifications to ensure they have been installed correctly and safely.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Sarah Catherine Tonkin, born 3 November 1982;

    b) the death occurred on 13 December 2019 at Bacchus Marsh-Geelong Road, Balliang, Victoria, 3340;

    c) I accept and adopt the medical cause of death as ascribed by Dr Joanna Moira Glengarry and I find that Sarah Catherine Tonkin died from blunt force head injuries, in the aforementioned circumstances.

I convey my sincere condolences to Sarah'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:

Nadia Lucas of Maurice Blackburn on behalf of Gregor Jeffrey, Senior Next of Kin

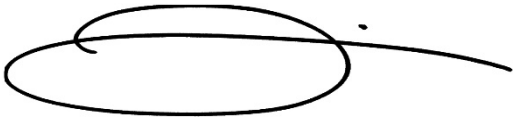
Leading Senior Constable Jason Barry-Bassett, Coroner's Investigator

Transport Accident Commission

VicRoads

National Heavy Vehicle Regulator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 July 2024

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.