IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005647

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Sharon O'Neill
Date of birth:	9 April 1957
Date of death:	1 October 2022
Cause of death:	HEAD AND NECK INJURIES SUSTAINED IN A MOTOR SCOOTER INCIDENT
Place of death:	200 Hume Highway, Somerton, Victoria, 3062

INTRODUCTION

1. On 1 October 2022, Sharon O'Neill was 65 years old when she died in a motor scooter incident at Somerton, Victoria. At the time of her death, Ms O'Neill lived in Caulfield North, Victoria.

THE CORONIAL INVESTIGATION

2. Ms O'Neill'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 Senior Constable (SC) Heath Chamberlain to be the Coronial Investigator for the investigation of Ms O'Neill's death. SC Chamberlain conducted inquiries on my behalf and compiled a coronial brief of evidence. The coronial brief includes information and records from Victorian WorkCover Authority (**Worksafe)** regarding their investigation into the death of Ms O'Neill.

6. This finding draws on the totality of the coronial investigation into the death of Ms O'Neill 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.

BACKGROUND

7. Ms O'Neill was born in Wellington, New Zealand, and had one younger sibling.

8. Ms O'Neill commenced a relationship with Gerard Mangos in 1975 and they moved back and forth several times between Australia and New Zealand before eventually settling permanently in Australia. Ms O'Neill and Mr Mangos had two children together, both of whom were adults at the time of Ms O'Neill's death. Ms O'Neill and Mr Mangos separated in 2015.

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

Circumstances in which the death occurred

9. On the morning of Saturday, 1 October 2022, Ms O'Neill attended the Honda Australia Rider Training facility (**HART**) at Somerton, Victoria, to undertake a motorcycle learner rider beginner course. Ms O'Neill held a full Victorian driver licence for a motor car.

10. HART is located at 200 Hume Highway in Somerton. The facility is set back from the road with a paved training area that measures 76 metres from east to west and 123 metres long from north to south. A building is located on the east side of the training area, and a carpark and outdoor eating area are also located nearby. The training area includes a large oval bitumen sealed track, enclosed by 'chain link' wire mesh fencing[2] approximately 2.1 metres high.

11. The first hour of the training was a theory lesson which took place in a classroom at HART. At 9.00am, the students commenced practical training in the training area. They were taught the basics of how to start and stop a motorcycle, and then practised drills which involved riding forward at a slow speed and stopping, with no steering input. The motorcycles used for the drills had manual transmissions.

12. Ms O'Neill's instructor, Jonathon Bowen, and one of the students in the class stated that Ms O'Neill appeared to be struggling to control her motorcycle during the initial drills.

13. Accordingly, Mr Bowen recommended that Ms O'Neill swap to a scooter with an automatic transmission, a 2015 Honda MW110 Scooter (**the motor scooter**) provided by HART. She

[2] Colloquially, a "Cyclone fence".

appeared to be happy with this change and was observed to demonstrate greater control of the motor scooter when completing subsequent drills.

14. At 10.55am, the students were instructed to undertake an exercise which involved accelerating and turning in a controlled manner.

15. Ms O'Neill was the second student to perform the drill and started at 10.59am. She initially travelled slowly eastwards. Her speed then increased. Mr Bowen stated that she appeared to panic and twisted the throttle to the maximum. Ms O'Neill's motor scooter impacted the gutter surrounding the training area, and then the fence. Ms O'Neill's neck struck a middle guide wire, which held the fence to vertical poles, and both she and the scooter then slid under the fence, coming to rest approximately six metres away.

16. Ms O'Neill was wearing a helmet but had sustained a significant laceration to her neck. Mr Bowen directed the other students to contact emergency services and immediately provided first aid. Ambulance Victoria paramedics arrived at 11.05am and took over the treatment of Ms O'Neill. However, despite their best efforts, Ms O'Neill succumbed to her injuries and was declared deceased at the scene at 11.48am.

Identity of the deceased

17. On 6 October 2022, Sharon O'Neill, born 9 April 1957, was visually identified by her former husband, Gerard Mangos.

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

Medical cause of death

19. Forensic Pathologist, Dr Yeliena Baber of the Victorian Institute of Forensic Medicine, conducted an examination on 3 October 2022 and provided a written report of her findings dated 7 October 2022.

20. The post-mortem examination revealed findings in keeping with the described circumstances. A post-mortem computed tomography (CT) scan showed a large base of skull fracture. There were multiple fractures of the anterior cranial fossa, pneumocranium, left pneumothorax, air in the right ventricle, and anterolateral rib fractures (2^{nd} to 6^{th} right ribs and 3^{rd} left rib).

21. Toxicological analysis of post-mortem samples identified the presence of temazepam, mirtazapine, hydroxychloroquine, loratadine and paracetamol.

22. Dr Baber provided an opinion that the medical cause of death was '1 (a) Head and neck injuries sustained in a motor scooter incident'.

23. I accept Dr Baber's opinion.

WorkSafe Investigation

24. WorkSafe conducted an investigation following Ms O'Neill's death. The motor scooter was examined and there was no evidence of any defects which would hinder vehicle performance or handling.

25. WorkSafe also obtained a report from road safety consultant, Mr Duncan McRae, in relation to motorcycle training range fencing and other control measures in place to support rider safety, particularly in relation to novice riders.

26. Mr McRae noted that the primary function of fencing at rider training ranges is to keep members of the public away from the training range. Further, the HART training range was set out in accordance with Department of Transport and Planning (**DTP**) requirements, which are standardised across all training sites in Victoria.

27. Mr McRae also noted that chain mesh fencing was an appropriate type of fencing to be used at rider training ranges, and it met DTP requirements. Mr McRae stated that he had previously observed incidents involving riders colliding with this type of fence. He explained that it 'acted as a "catcher's glove" and caught the rider, with some give in the fence. This is preferable to a rigid fence or solid wall.'

28. It was also noted that 'throttle freeze' is a common occurrence in novice riders, and learner programs go through several training steps to address this issue, performing training in a 'layering manner', where skills are progressively added.

29. Mr McRae noted that it is now uniform across Victoria for training ranges to be smaller, which allows for the speed of students to be controlled more easily. The smaller area ensures riders cannot achieve the high speeds that might be reached on an open range and allows for better and closer supervision. Riders are instructed not to exceed 30 km/h when training. The smaller range areas also allows for greater repetition in training.

30. Mr McRae explained that throttle limiters have been trialled in the past, but these trials were unsuccessful, and the limiters did not effectively achieve the goal of limiting speed. As a result, they are no longer used.

31. Mr McRae suggested that modifications such as inner padding or plastic barriers inside chain mesh fencing could be considered to prevent similar incidents occurring in the future.

32. WorkSafe conducted an inspection of the HART facility and issued an improvement notice on 28 October 2022. The notice identified that there was a risk of impact causing serious injury with other objects by students learning to ride a motorcycle or scooter, due to inadequate impact safety systems. The improvement notice required compliance by 24 February 2023.

33. WorkSafe conducted a follow-up inspection on 31 January 2023. They confirmed that HART had completed a range of works to comply with the improvement notice. This work included the installation of an inner perimeter of approximately 400 interconnected orange and white barriers[3] around the training range, and the replacement and upgrade of the outer perimeter chain mesh fence. WorkSafe noted that the entire motorcycle training range was now surrounded by a soft impact safety system, with buffer zones leading to the outside perimeter chain mesh fencing.

Review by Department of Transport and Planning

34. On 18 July 2024, Safe System Solutions Pty Ltd, consultants to the DTP, delivered its *Motorcycle Training Assessment Facility/Equipment Review* (**the review / the Safe Systems review**). The review considered multiple aspects of training facility design, including barriers and fencing. It noted that the purpose of fencing was to prevent access of unauthorised persons, whereas barriers were typically designed to prevent errant vehicles from leaving the roadway. However, the difficulty with most barriers is that they are designed and tested[4] to stop cars and trucks leaving the roadway, rather than motorcycles.

35. Recognising the need for infrastructure at rider training facilities that is suited to motorcycles, the Safe Systems review adopted the term 'containment devices'. It noted that containment devices have not undergone the testing protocols that road barriers are subjected to, but they may be appropriate to stop a motorcycle leaving the area of the test pad at a rider training facility. The review concluded that the criteria for containment devices at rider training

[3] The barriers are of the type constructed of high density polyethylene (HDPE), which can be interlocked and water filled.

[4] Barriers are tested in controlled conditions as per the American Association of State Highway and Transport Officials (AASHTO) Manual for Assessing Safety Hardware (MASH) procedures.

facilities should be included in the DTP's Business Procedures Manual[5] (**BPM**) applicable to accredited motorcycle training providers. It recommended that containment devices should have the following characteristics:

(a) The ability to contain an errant motorcycle while avoiding risks of vaulting[6], gating[7], spearing[8], collapse and/or failure;
(b) Constructed to absorb the energy of a crash;
(c) Made of durable materials suitable for outdoor use that can be maintained and replaced;
(d) Minimum height of 1.2 meters;
(e) Rounded-head coach bolts for fastening where used; and
(f) Smooth faced on the top and sides (i.e., not have snagging hazards).[9]

(**the review recommendations**)

36. The review did not recommend that the DTP adopt a prescriptive approach for the type of containment devices used by training providers. Rather, it suggested that the 'DTP consider the form and expected safety performance of the containment device on a case-by-case basis.' In practice, this means that a properly constructed tyre wall may be appropriate, or water filled plastic barriers (which are only partly filled)[10] may be suitable.

37. The review also considered the fencing and barriers described in *Motorsports Australia's Track Standards* document. It was noted that these structures had been developed for high speed environments but some of the requirements were appropriate to apply to rider training facilities, these are:

(a) Containment devices and barriers must not be flammable.
(b) Containment devices and barriers can be purchased or may be self-constructed.
(c) Purchased containment devices and barriers must be installed as per manufacturer requirements.

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5 The Business Procedures Manual is the key process document that outlines the processes that accredited providers must follow when providing motorcycle rider training and assessment services on behalf of the Secretary to DTP, e.g. test pad requirements, facility requirements, trainer requirements etc.
6 An abrupt upward movement of a colliding motorcycle. A vaulting risk infers the barrier / containment device has the potential to act as a ramp.
7 The ability for colliding motorcycles to pass through the barrier / containment device.
8 A reference to elements of the barrier / containment device potentially becoming detached during a motorcycle collision and penetrating the rider and/or people within the vicinity.
9 At section 6.3.1, pages 23 to 24
10 There is no guidance as to how much water a water-filled barrier should contain to be motorcycle compatible, noting that these devices are designed with passenger vehicles in mind. Two separate training providers advised the reviewers that they used water-filled barriers that were only partially filled with water (to approximately 20%).

(d) Containment devices and barriers must form a continuous wall around the range, with breaks only at range entry/exit points.

38. On 21 February 2025 the Court inquired of the DTP whether it had implemented the review recommendations or intended to do so.

39. On 29 April 2025, the DTP advised as follows:

> *… The key business areas are in the final stages of briefing senior leadership on the recommendations that are proposed to be implemented in the short term. Preliminary work has also been undertaken to prepare amended policy documents to facilitate the implementation process. It is anticipated that these final steps will be concluded within the next three months. Following this, the Department intends to consult with key industry stakeholders in relation to the proposed policy changes.*
>
> *As such, the Department is presently unable to confirm which of the recommendation/suggestions have been accepted and how any new requirements for rider training facilities will be implemented. However, it will advise the coroner in due course when its position has been finalised.*

40. I consider that the review recommendations are clear and should be implemented by the DTP. Indeed, the practicability of installing containment devices of the type contemplated has been demonstrated by the remedial action taken by HART. It is also appropriate that the review recommendations be reflected in a coronial recommendation.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Sharon O'Neill, born 9 April 1957;

b) the death occurred on 1 October 2022 at 200 Hume Highway, Somerton, Victoria, 3062, from head and neck injuries sustained in a motor scooter incident; and

c) the death occurred in the circumstances described above.

42. Ms O'Neill was a novice motorcycle rider, and she was riding an unfamiliar motor scooter. I am satisfied that these factors underlie her inability to control the motor scooter, which led to her collision with the fence. However, the incident occurred at a learner rider training facility, where inexperience and lack of familiarity are to be expected, and both the training program

and the facilities must be designed to reduce, as far as is practicable, the risks associated with learning to ride a motorcycle or motor scooter.

43. I am satisfied that the training provided to Ms O'Neill by HART was appropriate in the circumstances, and the motor scooter had no mechanical defects which contributed to the incident.

44. I note the opinion of Mr McRae that wire mesh fences are generally appropriate for use at learner rider training facilities. I also accept that such fences may act in a 'catcher's glove' fashion when hit by a motorcycle / motor scooter rider. It may be rare for a collision between a rider at a training facility, and a fence of this type, to result in serious injury. Nonetheless, wire mesh fences are not designed to safely arrest a rider of a motorcycle or motor scooter colliding with the fence. There are components of wire mesh fences that are rigid and capable of causing serious injury (such as the upright steel poles). There are also elements of the wire matrix that may fail in a way that can cause lacerations or other serious injuries.

45. If the perimeter of the training area had been bounded by a containment device with the characteristics recommended by the Safe Systems review, or the barriers that were subsequently installed at the facility, it is almost certain that Ms O'Neill would not have collided with the wire mesh fence. While the recommended containment devices cannot entirely eliminate the risk of injury, it is highly likely that Ms O'Neill would have been spared the grievous injuries arising from impact with the fence.

46. I am satisfied that HART have undertaken significant work to ensure that additional safety measures are now in place at their training facility to prevent similar incidents occurring in the future.

RECOMMENDATION

I make the following recommendation under section 72(2) of the Act –

1. That the Department of Transport and Planning implement the recommendations detailed at section 6.3.1 of the review by Safe System Solutions Pty Ltd dated 18 July 2024 (titled *Motorcycle Training Assessment Facility/Equipment Review*) in respect of amendments to its Business Procedures Manual to require appropriate containment devices at motorcycle rider training facilities.

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

I convey my sincere condolences to Ms O'Neill's family for their loss.

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

Scott Mangos, Senior Next of Kin

Melissa Mangos, c/- LHD Lawyers

Department of Transport and Planning

Honda Australia Pty Ltd

Senior Constable Heath Chamberlain, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date : 29 May 2025

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.