IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006610

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Peigi Frances Hudson
Date of birth:	12 January 1947
Date of death:	17 November 2022
Cause of death:	1(a) TRAUMATIC ASPHYXIA IN THE SETTING OF A TREE FALLING ONTO A MOVING VEHICLE (PASSENGER)
Place of death:	South Rock Road, Woodend, Victoria, 3442
Keywords:	Motor vehicle collision, tree impact, roadside hazards, rural roads

INTRODUCTION

1. On 17 November 2022, Peigi Frances Hudson was 75 years old when she was struck by an uprooted tree which fell onto the roof of a motor vehicle driven by her partner, Robert Maskell. This incident resulted in her death.

2. At the time of her death, Ms Hudson resided with Mr Maskell at 678 Rochford Road, Rochford.

THE CORONIAL INVESTIGATION

3. Ms Hudson'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. Leading Senior Constable (LSC) Brian Smith acted as the Coroner's Investigator for the investigation of Ms Hudson's death. LSC Smith conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Ms Hudson, 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

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

Circumstances in which the death occurred

8. At approximately 1.30pm on 17 November 2022, Ms Hudson and Mr Maskell left their home in Rochford in Mr Maskell's Range Rover wagon (**the vehicle / the Range Rover**) to collect medication from a pharmacy in Romsey. Mr Maskell was driving, and Ms Hudson was seated in the front passenger seat.

9. Ms Hudson and Mr Maskell then travelled to Woodend. At approximately 2.45pm they left the Woodend township via Romsey Road and travelled northeast before turning left (north) onto Coach Road and then right (north-east) onto South Rock Road. In the vicinity of the critical events, South Rock Road runs straight and flat. It is a narrow rural road comprised of a single lane in each direction, divided by a broken white line. The road surface is sealed bitumen and appears in good condition. There is no fog line or shoulder at the road's edge. Abutting the sealed roadway there is a flat grassy margin approximately 2 metres wide before giving way trees that line both sides of the road.

10. After travelling for approximately 400 metres on South Rock Road, a large tree branch snapped and fell onto the road. Mr Maskell immediately steered into to the opposite lane to avoid the fallen branch.

11. As Mr Maskell was about to return to the northeast bound lane, a large tree[2] next to the north-east side of the road fell diagonally across the road and onto the vehicle's roof. The fallen tree had stood approximately 30 metres tall. The main trunk (just at the point of the primary bifurcation) landed at an angle from the rear of the vehicle and, save for a narrow margin along the driver side, crushed the entirety of the cabin down to the approximate height of the bonnet.

12. Maddie Ryland was driving behind the Range Rover and saw first manoeuvre around the fallen branch and then saw the impact as the large tree fell. She stopped and rushed over to help and contacted emergency services. Moments later, Matthew Carter drove up to the scene and helped Mr Maskell out of the vehicle. However, Ms Hudson appeared unresponsive and was trapped in the front passenger seat.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] The tree appears to be a "messmate stringybark" – *Eucalyptus obliqua*

13. LSC Smith arrived at 3.21pm and paramedics were already on scene attending to Mr Maskell. It was not possible to get to Ms Hudson until many of the branches had been cut away which would then allow a forklift to be used to lift the remaining trunk. This was a difficult operation performed by members of the State Emergency Service and employees of the Macedon Ranges Shire.

14. It was not until 5.46pm that a MICA paramedic could properly assess Ms Hudson, at which time she was found to be deceased.

15. Mr Maskell sustained non-life-threatening injuries and was conveyed to the Royal Melbourne Hospital for treatment.

16. Police examined the scene as part of a wider investigation. They ascertained Ms Hudson and Mr Maskell were both wearing seatbelts. Inspection of the vehicle revealed no evidence to suggest that any defect or malfunction played a role in the events. There was also no evidence to suggest that distraction, excessive speed or driver impairment were contributing factors. Indeed, the evidence of Ms Ryland suggests that the vehicle was being driven carefully.

17. LSC Smith examined the fallen tree and provided an opinion that recent heavy rains may have contributed to the uprooting of the tree. Data from the Bureau of Meteorology indicates that rainfall in October 2022 was either "very much above" average or the "highest on record" throughout most of Victoria.[3]

Identity of the deceased

18. On 24 November 2022, Peigi Frances Hudson, born 12 January 1947, was identified via dental record comparison.

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

Medical cause of death

20. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 18 November 2022 and provided a written report of his findings dated 13 December 2022.

[3] Bureau of Meteorology, Recent and Historical Rainfall Maps, October 2022 http://www.bom.gov.au/climate/maps/rainfall/?variable=rainfall&map=decile&period=month&region=vc&year=2022&month=10&day=31 (accessed 25 March 2024).

21. The post-mortem examination revealed pallor to the torso, left arm and legs, and marked congestion with petechial haemorrhage to the right arm. No significant skeletal trauma or soft tissue injuries were identified. Dr Bouwer commented that these findings were highly suggestive of a traumatic asphyxia type of death, caused by the intrusion of the tree into the vehicle via the vehicle's roof.

22. Toxicological analysis of post-mortem samples identified the presence of temazepam and paracetamol, which are non-contributory to death.

23. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) traumatic asphyxia in the setting of a tree falling onto a moving vehicle (passenger).

24. I accept Dr Bouwer's opinion.

FURTHER INVESTIGATIONS

25. LSC Smith was able to identify the tree in a Google "street view" image showing it before it fell. It leant across South Rock Road at approximately 30° from vertical, with its canopy extending over to the far side of the road. Measurements of the scene recorded that the tree had stood 7.1 metres from the nearest edge of the road and the road itself is 7.3 metres wide. The diameter of the trunk is not stated but, from photographs of the scene, the diameter of the portion that impacted the vehicle appears to be approximately half the width of the vehicle itself. Quite simply, this was a massive tree leaning across the road at a considerable angle and its impact on the vehicle was catastrophic.

26. I sought further information from Macedon Ranges Shire Council (**the Council**) regarding the maintenance of trees along South Rock Road. The Council advised that they are not the responsible road authority for the relevant section of South Rock Road.

27. I also sought further information from the Department of Transport and Planning (**DTP**) in relation to the routine maintenance performed on roadside hazards along South Rock Road.

28. The DTP advised that South Rock Road is part of Mount Macedon – Hanging Rock Road, a Category 5 road within the Road Management Plan 2021. It is classified as an arterial road for which Transport for Victoria (**TfV**) is the coordinating road authority, within the meaning of

the *Road Management Act 2004*. TfV is responsible for coordinating, providing, operating, and maintaining the public transport system and the road system in Victoria.[4]

29. However, TfV's statutory duty does not extend to any roadside or other area of a public road that has not been developed by a road authority for use by the public as a roadway or pathway, including bushland for public use. As such, the DTP's responsibilities do not extend to actively managing vegetation outside the road and does not include any proactive programs to identify dangerous trees.

30. Due to the multitude of trees along regional roads, trees are generally only assessed when a member of the public notifies the DTP of a potential hazard, or when staff undertake defect and hazard inspections. If a reported tree poses a potentially hazardous risk to road users, the DTP will schedule a routine maintenance inspection that involves treatment or inspection by an arborist. An examination of the history of reports[5] from the public pertaining to South Rock Road reveals that the majority of the reports relate to branches or trees that have already fallen, rather than standing trees that appear to be a hazard.

31. The DTP confirmed that the trees along South Rock Road have been inspected upon notification and removed or trimmed when required. However, there has been no proactive assessment of the trees along South Rock Road, as roadside vegetation is not part of the DTP's maintenance responsibility. Accordingly, the identification of potentially dangerous trees near rural roads (such as South Road Road) relies very heavily on reports from the public.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Peigi Frances Hudson, born 12 January 1947;

    b) the death occurred on 17 November 2022 at South Rock Road, Woodend, Victoria, 3442, from traumatic asphyxia in the setting of a tree falling into a moving vehicle (passenger); and

    c) the death occurred in the circumstances described above.

[4] Head, TfV has taken over the road management responsibilities of the Roads Corporation (VicRoads) and has been a part of Department of Transport and Planning (**DTP**) since joining the DTP.

[5] ETS records provided by Head, Transport for Victoria – 31 relevant reports (not including the report pertaining to these events) dating back to November 2017.

33. Having considered all the circumstances, I find that the death was the result of a tragic accident caused by the fall of a massive tree. There is insufficient evidence for me to make a finding regarding any specific contributing factors that may have made the tree more susceptible to uprooting and falling.

34. Ms Hudson's tragic death highlights the importance of the role for members of the public as a key source of information concerning roadside hazards such as dangerous trees. The sheer nature of Victoria's road network, and particularly the rural road network, means that the responsible authorities must, at least to a certain extent, rely on reports from the public. It is also important that the avenues for reporting are straightforward and encompass multiple methods of contact by a member of the public. Accordingly, with the aim of reducing the number of preventable deaths associated with these hazards and to promote public health and safety, I make the recommendation below.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation directed to Head, Transport for Victoria and the Municipal Association of Victoria –

> That Head, Transport for Victoria and the Municipal Association of Victoria consider coordinating with rural Shire and City Councils, particularly those with a large tree stock near rural roads, to conduct regular public information campaigns to highlight the importance of reporting by members of the public of dangerous trees (and other roadside hazards), and the avenues available for such reporting.

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

I thank the Coroner's Investigator and those assisting for their work in this investigation.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroner's Court of Victoria website in accordance with the rules.

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

> Robert Maskell, Senior Next of Kin
>
> Mark Colautti, Department of Transport and Planning

Head, Transport for Victoria

Municipal Association of Victoria

Leading Senior Constable Brian Smith, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 01 August 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.