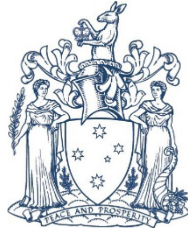

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006644

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Baran Yalcin
Date of birth:	3 September 1993
Date of death:	19 November 2022
Cause of death:	1a: INJURIES SUSTAINED IN A MOTOR VEHICLE COLLISION (BICYCLE RIDER)
Place of death:	Intersection of St Georges Road and Miller Street, Thornbury, Victoria, 3071
Keywords:	Motor vehicle collision, electric bicycle, food delivery driver

INTRODUCTION

1. On 19 November 2022, Baran Yalcin[1] was 29 years old when he died in a motor vehicle collision while riding his electric bicycle. At the time of his death, Baran lived in Reservoir with a friend.

2. Baran was a Turkish international student and worked as a cleaner and food delivery service driver. He is described by his friends as an intellectual and energetic individual who loved football, movies and books. He loved learning about the world, and was excited to experience new things in Australia.

THE CORONIAL INVESTIGATION

3. Baran'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 an officer to be the Coronial Investigator for the investigation of Baran's death. The Coronial Investigator conducted inquiries on the Court's 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. Then-Deputy State Coroner Jacqui Hawkins originally held carriage of the investigation into Baran's death until it came under my purview in October 2023 for the purposes of obtaining additional material, finalising the investigation and handing down these findings.

[1] Referred to throughout this finding as 'Baran', unless more formality is required.

8. This finding draws on the totality of the coronial investigation into the death of Baran Yalcin 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. On 12 February 2022, shortly after 10:30pm, Baran was riding his electric bicycle (**e-bicycle**) on St Georges Road in Preston. It is unclear from the evidence whether he was simply returning from his job as a cleaner or also making a food delivery *en route* home.

10. The bicycle path on St Georges Road stretches between two lanes of traffic. At the intersection with Miller Street, the path reaches a small concrete island and pedestrian crossing, before continuing alongside St Georges Road.

11. At the time, Baran was wearing a helmet, and his e-bicycle was fitted with a light, which was switched on.

12. Baran reached the concrete island. The pedestrian crossing displayed a red light; the traffic lights for motorists on St Georges Road crossing through the intersection, was green. A witness on the opposite site of the pedestrian crossing recalls that *'the lights at the pedestrian crossing were clearly red'*.

13. Baran momentarily stopped on the concrete island though continued to enter the intersection. As he did so, a witness heard *'very hard [vehicle] braking'* at which time a van towing a trailer, travelling on St Georges Road, entered the intersection and collided with Baran.

14. A nearby cyclist contacted emergency services and multiple witnesses began providing assistance to Baran. A witness recalls she felt Baran's pulse weaken, and she commenced cardiopulmonary resuscitation (**CPR**). Fire Rescue Victoria arrived at the scene and took over resuscitation efforts, followed shortly thereafter by Ambulance Victoria paramedics.

15. At 10:50 pm, Ambulance Victoria paramedics declared Baran deceased.

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[2] 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.

IDENTITY OF THE DECEASED

16. On 23 November 2022, Baran Yalcin, born 3 September 1993, was visually identified by his friend, who completed a formal Statement of Identification.

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

MEDICAL CAUSE OF DEATH

18. Forensic Pathologist Dr Victoria Francis (**Dr Francis**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 21 November 2022. Dr Francis considered the Victorian Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of her findings dated 6 January 2023.

19. The post-mortem examination revealed multiple abrasions and lacerations about the body including to the head. The post-mortem CT scan demonstrated mandibular, facial and rib fractures.

20. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

21. Dr Francis provided an opinion that the medical cause of death was 1(a) *injuries sustained in a motor vehicle collision (bicycle rider)*.

22. I accept Dr Francis' opinion.

INVESTIGATION BY VICTORIA POLICE

23. Victorian Police apprehended the driver of the van (**the motorist**) and conducted an interview in the hours following Baran's death.

24. In the interview, the motorist stated he *'barely had any time to react at all'* and *'tried to brake and – and swerve'*. The motorist stated he was not fatigued and was not distracted at the time of the incident.

25. A blood sample was obtained from the motorist, and which demonstrated the presence of methadone at a concentration of approximately 0.12 mg/L. I sought an opinion from Dr Doorendranath Sanjeev Gaya (**Dr Gaya**) of VIFM as to whether this concentration of methadone may have impacted the motorist's driving capacity.

26. In Dr Gaya's report it was concluded that, on the material available, it is *'more likely that [the motorist's] driving ability was not significantly compromised by the methadone detected in his blood sample'.*[3] I accept Dr Gaya's opinion.

27. Victoria Police did not lay charges against the motorist.

Mechanical inspection of Baran's e-bicycle

28. Senior Constable Daniel Pearce (**SC Pearce**) of the Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) completed a mechanical inspection on Baran's e-bicycle and provided a copy of his written report on 15 March 2023.

29. SC Pearce's examination *'did not reveal any faults, failures or conditions that could have caused or contributed to the collision'.*

Reconstruction of the collision

30. Detective Leading Senior Constable Lindon Walker (**DLSC Walker**) of the CRMIU was supplied with photographs and measurements of the collision scene and requested to determine the speed of the van at the time it struck Baran.

31. At the time of the collision, the road was dry, and visibility was good, with several streetlights illuminating the road. The relevant stretch of St Georges Road has a posted speed limit of 70 kilometres per hour (**km/h**).

32. Attending Victoria Police members identified two parallel scuff marks on St Georges Road which extended for approximately 18.2 metres. DLSC Walker stated *'these tyre scuff marks were identified as tyre skid marks'* and which extended beyond the point of impact.

33. DLSC Walker estimated the speed of the van at the time it approached the intersection and determined it to be *not less than 65 km/h and not more than 72 km/h'*. He continued that *'the [van] had been skidding when the impact occurred'* and that, at the time of the collision, was travelling *'not slower than 46 km/h and not faster than 56 km/h'.*

34. While certain witnesses suggested that the van appeared to be travelling fast and took some time to reduce its speed, I accept the opinion of DLCS Walker that the motorist in the van was not using excessive speed and that evasive action was taken prior to the collision.

[3] Dr Gaya did not have access to the motorist's medical history and therefore could not reach a definitive conclusion.

Whether Baran was working as a food delivery driver at the precise time of the collision

35. For completeness, I note that the evidence is unclear as to whether Baran was working as a food delivery rider at the time of the collision. The Coronial Investigator reported that Baran's mobile phone was unable to be interrogated following the incident and that it was not submitted for analysis. It was also indicated that Baran's teal-coloured insulated bag affixed to his bicycle was empty, indicating that he was not *en route* to a delivery. However, it remains possible that he may have recently completed a food delivery, or was travelling to collect items for a delivery.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Baran Yalcin, born 3 September 1993;

    b) the death occurred on 19 November 2022 at Intersection of St Georges Road and Miller Street, Thornbury, Victoria, 3071, from 1(a) *injuries sustained in a motor vehicle collision (bicycle rider)*; and,

    c) the death occurred in the circumstances described above.

37. Having considered the evidence, I find that the fatal collision was caused by Baran Yalcin entering the intersection against a red light and oncoming traffic. On the material before me, I am unable to determine the exact reason for which he entered the intersection.

38. However, I find that Baran Yalcin was by no means indifferent to his safety, noting he was wearing a helmet and his bike was fitted with a light that was operating at the time of the collision. He was not affected by drugs or alcohol.

39. I find that, when Baran Yalcin entered the intersection against the red light, the motorist in the van had insufficient time to bring his vehicle to a stop prior to the impact. Evidence points to the motorist travelling at or around the posted speed limit. I acknowledge that methadone was detected in the motorist's blood sample following the collision, however, I accept and adopt Dr Gaya's opinion that on the available evidence, it is unlikely this significantly compromised the motorist or contributed to the collision.

COMMENTS

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

1. I note that Baran, an international student, was working as both a cleaner and as a food delivery driver at the time of his death.

2. While the circumstances surrounding his decision to enter the intersection cannot now be known (nor is it known whether Baran was delivering food at the precise time of the collision), I note there are longstanding concerns about the risks faced by food delivery workers (including those who use bicycles and e-bicycles, such as Baran, and who are therefore particularly vulnerable on the roads) and the conditions in which they work. Food delivery workers may encounter a range of hazards in their jobs that pose risks to both their physical and psychological safety, including economic and time pressures, riding on unfamiliar roads, and the effects of physical exertion, shift work and fatigue.

3. I am informed by the Coroners Prevention Unit that, since 2020, there have been five road deaths of food delivery workers in Victoria (two of whom were working from their cars, one of whom rode a scooter and two, including Baran, who used a bicycle). Nationally, the figure is much higher.

4. To this end, and while noting that the issue of the conditions under which food delivery workers operate is currently being considered in another jurisdiction, being the Fair Work Commission (including the question of setting enforceable minimum standards for 'employee-like' workers in the 'gig' economy), I have elected to notify my findings to WorkSafe Victoria and the Transport Accident Commission, to assist in informing any future initiatives geared towards improving the broader safety of food delivery workers on Victorian roads.

I convey my sincere condolences to Baran's family for their loss. It is a tragedy that a young man who had only recently arrived in Australia, and who is described as being energetic, healthy and excited to start a new life in Melbourne, died in such circumstances.

I express my gratitude to Leading Senior Constable Nicholas Trusewicz and Detective Leading Senior Constable Lindon Walker for their assistance and providing the Court with additional evidence at my request, and in responding to certain concerns raised by Baran's family. I also express my gratitude to Baran's family for expressing their concerns, seeking clarification regarding aspects of the evidence, and contributing to a comprehensive coronial investigation.

ORDERS AND DIRECTIONS

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

Dogan Yalcin, Senior Next of Kin

Berfin Sila Yalcin

WorkSafe Victoria

Safe Work Australia

Transport Accident Commission

Senior Constable Nicholas Trusewicz, Coronial Investigator

Signature:

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Coroner Ingrid Giles

Date: 06 February 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.