



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002868

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Ingrid Giles
Deceased:	Rhiannon Charlotte Drake
Date of birth:	22 September 1992
Date of death:	29 May 2023
Cause of death:	1(a) Head injuries sustained in a motor vehicle incident (passenger)
Place of death:	Princes Highway Nilma Victoria 3821
Keywords:	Roadside mowing operations; warning signs; looming collision; improved safety measures; peak hour; variable messaging signs; traffic management plan

INTRODUCTION

1. On 29 May 2023, Rhiannon Charlotte Drake¹ was 30 years old when she died from injuries sustained in a motor vehicle collision. At the time of her death, Rhiannon lived in Warragul, Victoria.

THE CORONIAL INVESTIGATION

2. Rhiannon'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 Coronial Investigator for the investigation of Rhiannon'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.
6. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Rhiannon's death. I assumed carriage in October 2023 for the purposes of conducting additional investigative steps, finalising the case, and making findings.
7. This finding draws on the totality of the coronial investigation into the death of Rhiannon Charlotte Drake 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

¹ Referred to throughout my finding as 'Rhiannon', unless more formality is required.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²

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

Circumstances in which the death occurred

8. On the evening of 28 May 2023, Rhiannon stayed at the home of her friend, Samantha Armstrong (**Samantha**), in Warragul, Victoria. The next morning, Samantha left home with her three children (one daughter, two sons) and Rhiannon in her silver 2005 Jeep Cherokee wagon (**the Jeep**). Rhiannon was seated in the front passenger seat, and the three children were in the rear passenger seats. They left home at 8.18am and arrived at Darnum Primary School, where Samantha dropped off her two sons. Samantha estimated that she spent about five minutes at Darnum Primary School and left at about 8.35am.
9. Samantha drove onto the Princes Freeway to head back to Warragul, to drop her daughter off at Warragul Regional College. At about 8.40am, she travelled west along the Princes Highway. She stated that she observed a flashing sign on the back of a truck depicting road works ahead. She estimated the sign was about 150 metres ahead of her and she was travelling in the left lane at 110km/h.
10. In front of the Jeep, there was a white 2010 Mitsubishi Outlander wagon (**the Mitsubishi**), driven by Mark Loft. In front of the Mitsubishi, there was a silver 2007 Mazda 3 sedan (**the Mazda**), driven by Layla Williams. Behind the Jeep, there was a man driving a 2018 Fuso Truck carrying a skip bin (**the Fuso**), which was registered to Meluca Group Pty Ltd.
11. Samantha observed the vehicles in front of her starting to brake, and she also applied the brakes. She recalled that she had to *“slam her brakes on really hard, [she] went from 110km/h to zero, [she had] never slammed [her] brakes on like that before”*. Mr Loft similarly described that when he realised the traffic ahead was stationary, he had to brake harder than he originally thought.
12. Samantha observed the Fuso in her rear vision mirror and estimated he was travelling at about 100km/h. She stated that she tried to turn her Jeep into the left emergency lane, however, was

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.

unable to move out of the way before the Fuso collided with the rear of the Jeep. Samantha described the collision as “*horrendous*”.

13. The force of the collision propelled the Jeep into the left emergency lane, into the wire rope barrier, rotating before it came to rest. The Fuso also collided with the rear of the Mitsubishi, and the Mitsubishi collided with the Mazda, at least twice. The Mitsubishi came to rest in a culvert, on the grass shoulder that bordered the left-hand side of the road. After being impacted by the Mitsubishi, the Mazda continued off the road, onto the grass shoulder, and came to rest at the beginning of the wire rope barrier.
14. After the Jeep came to rest, Samantha checked on her daughter and Rhiannon. Both were unresponsive. While she was able to find a pulse on her daughter, she could not feel a pulse when she checked Rhiannon. Samantha recalled that Rhiannon was leaning over to the right and there was blood coming from her mouth.
15. Emergency services were notified and promptly attended the scene. Paramedics treated Rhiannon at the scene, however she succumbed to her injuries and the scene and passed away. Samantha suffered abdominal bleeding and bruising, and was first taken to Warragul Hospital, and was then airlifted to the Royal Melbourne Hospital. Samantha’s daughter suffered bruising, a scalp haematoma and left shoulder pain. She was airlifted to the Royal Children’s Hospital.
16. Both Samantha and her daughter survived the collision. Mr Loft’s son (who was the front passenger) sustained serious injuries and survived. Ms Williams only sustained minor injuries, while the Fuso driver did not sustain any injuries.

Identity of the deceased

17. On 2 June 2023, Rhiannon Charlotte Drake, born 22 September 1992, was visually identified by her mother, Sally-Anne Drake.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on 30 May 2023 and provided a written report of her findings dated 31 May 2023.

20. Examination of the post-mortem computed tomography (CT) scan showed a base of skull fracture, basal subarachnoid haemorrhage, blood in the fourth ventricle, enhanced lung marking and sternal fractures.
21. The post-mortem external examination revealed findings consistent with the report circumstances.
22. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.
23. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Head injuries sustained in a motor vehicle incident (passenger).
24. I accept Dr Fronczek's opinion.

FURTHER INVESTIGATIONS

Victoria Police investigation

25. Following the collision, Victoria Police conducted a number of investigations. Police members tested the Fuso driver for drugs and alcohol; he was not found to be affected by either. His driver licence was current/valid, and the Fuso was appropriately registered.

Collision reconstruction

26. Detective Sergeant Dr Janelle Hardiman (**D/Sgt Hardiman**) attended the collision scene, examined the evidence and produced a collision reconstruction report. D/Sgt Hardiman explained that the Princes Highway, where the collision occurred, is a two-way, four-lane, divided road with two lanes in each direction. At the collision site, the road runs in a general southeast to northwest direction. The opposing lanes of traffic are divided by a wide grassy and treed median strip. The road is essentially straight with a gentle uphill gradient for northwest-bound vehicles.
27. Between Halletts Road and the area of impact (west bound), the road has a downhill gradient leading to a sag of about 450 metres, east of the area of impact. Between the road sag and the area of impact, there is a crest in the road. From the sag, the road beyond the area of impact is able to be seen and the upper section of some vehicles could be seen. However, drivers in passenger vehicles are impacted by the crest and cannot see other vehicles beyond the crest in the road. D/Sgt Hardiman explained that any obstruction created by the crest would be less

for drivers of trucks and vehicles with a higher ground clearance. She noted that a drive-through video recording taken on the day of the collision from a similar-sized truck to the Fuso showed a clear line of sight beyond the crest and up to the area of impact.

28. The road is constructed of bitumen and at the time of the collision it appeared to be in good condition. D/Sgt Hardiman did not observe any obvious damage or faults that would have caused or contributed to the collision. There is no provision for overhead street lighting as the area is classified as rural and is surrounded by large farming properties.
29. At the time of the collision, the right lane was closed beyond the area of impact due to roadside mowing that was occurring to the west of the area of impact. There was a mobile traffic management vehicle with an illuminated sign directing vehicles to merge into the left lane, which was following behind a tractor that was cutting the grass on the centre median strip.
30. D/Sgt Hardiman was unable to calculate the speed of the Fuso at the time of the collision. Based on the accounts of Samantha and Mr Loft, the Jeep was stationary at the time the Fuso collided with it. D/Sgt Hardiman calculated the minimum speed of the Jeep post-impact was between 72 and 84km/h, however she noted that if the Jeep was braking or any of the tyres were locked due to damage, then the actual post-impact speed would have been higher.
31. Based on the post-impact speed calculated (above), D/Sgt Hardiman calculated that at the time of impact with the Jeep, the Fuso was travelling between 90 and 105km/h. She noted there was no evidence in the form of tyre skid marks available at the scene to support pre-impact braking by the Fuso driver, although noted that he may have braked without leaving visible tyre marks. She concluded that there was no evidence that the Fuso was travelling above the speed limit.
32. D/Sgt Hardiman concluded that the collision was a “*looming collision*”. Looming occurs when a faster-moving vehicle (the Fuso) approaches a slower-moving vehicle (the Jeep) travelling in the same direction. She explained that physiologically, humans are not good at determining the speed at which they are approaching another vehicle from behind, so they may not be able to determine that they are gaining on a vehicle that is far away. It is not until the person is very close to the car ahead that they can accurately determine the speed of the vehicle in front.
33. When a vehicle approaches a stopped or slowed vehicle, the driver must estimate its speed based on how much the vehicle ahead looms or grows in their visual field. These crashes are difficult for approaching drivers as they are rare. D/Sgt Hardiman noted statistics

demonstrating that 34% of highway rear-end crashes involve a closing speed of greater than 48km/h, yet the probability of such an event occurring is less than 1%. As a result, closing speed is difficult to detect and the expectation that it will occur is extremely low.

34. D/Sgt Hardiman noted Samantha's statement that she had "*never slammed [her] brakes on like that before*". Similarly, Mr Loft noted that he began to slow when he saw the electronic arrow boards in the right lane ahead of him. As he approached the traffic that had merged to the left, he "*realised that they were in fact stationary. [He] had to break [sic] harder than [he] first anticipated but did not have to take evasive action*".

35. Mr Loft further noted:

None of the merging cars or traffic arrow signs were obscured, it was a fair way up the road, but I just didn't expect the traffic to be stationary as I approached...I saw the vehicle directly behind me, now in the left lane go a bit into the emergency lane to avoid hitting me from behind. I think we all thought the traffic would keep rolling and didn't realise it was stopped.

36. In this case, D/Sgt Hardiman noted (as above) that the Fuso was travelling between 90 and 105km/h at the time it collided with the Jeep, however, could not determine whether the Fuso was travelling at a constant speed, or whether it had slowed prior to impact. She could not determine how far behind the truck had been when Samantha first commenced braking. Samantha noted she braked harder than she had ever done before to slow from 110km/h to 0km/h. Under emergency braking, the Jeep could achieve a deceleration rate of more than 0.8g, while the Fuso was only able to achieve about 75% of a passenger vehicle deceleration without an Anti-lock Braking System (ABS). When considering why the driver of the truck failed to stop, D/Sgt Hardiman noted consideration could be given to other stimulus available to the driver of the truck, including the roadworks signs and the long line of merging traffic ahead. She opined:

[I]t appears that for unknown reasons, multiple drivers have failed to recognise and respond to this stimulus until it was too late and an emergency response was required. It should also be noted that there was another rear end collision in the left lane immediately behind the truck, involving two other unrelated vehicles.

37. D/Sgt Hardiman concluded that vehicles were merging into one lane (the left lane) when they were required to brake to a stop very quickly. The Fuso truck failed to stop before impacting

the rear of the Jeep, then the rear of the Mitsubishi, which subsequently impacted the rear of the Mazda. At impact with the Jeep, the Fuso was travelling between 90 and 105km/h and there is no evidence that the Fuso driver braked, however based on his impact speed, it was possible.

Examination of Fuso and Jeep

38. Senior Constable Daniel Walter (**SC Walter**) of the Collision Reconstruction and Mechanical Investigation Unit (**CRMU**) inspected the Fuso.
39. The Fuso sustained damage to the front, with the bonnet impacted and distorted. The windscreen was smashed and had partially fallen inside the cabin of the Fuso. SC Walter was able to start the Fuso (with a new battery installed) and found the accelerator, brakes and steering all functioned as expected. SC Walter did not identify any faults, failures or conditions that could have caused or contributed to the collision.
40. SC Walter also reviewed the Jeep, which sustained significant damage to the rear of the vehicle. SC Walter opined that upon his review, it was unlikely that the brake lights were illuminated at the time of the collision and that it was likely that the taillights were illuminated.

Criminal and WorkSafe prosecutions

41. Following a criminal investigation, Victoria Police did not charge the Fuso driver with any offences in relation to this incident, and it was recommended that WorkSafe conduct further investigations to determine whether any breach of the *Occupational Health and Safety Act 2004* obligations were apparent. No such breaches were found, and therefore no WorkSafe prosecution ensued. The Court was informed of the same on 14 August 2024.
42. As such, my own investigation could commence.

Department of Transport and Planning – Statement dated 17 January 2025

43. The Coronial Investigator informed the Court that the entity responsible for the ‘mobile slashing trailer’ (**MST**) conducting the grass mowing was the Department of Transport and Planning (**DTP**), which was cutting the grass on the median strip dividing the opposing lanes of traffic on the Princes Highway. At my direction, the Court contacted the DTP and requested a statement regarding the deployment of the MST on 29 May 2023.

44. DTP explained that on 29 May 2023, Fulton Hogan was contracted by DTP to perform the grass cutting works on the Princes Highway. They implemented a traffic management plan (TMP) for safety and provided a copy of the TMP to the Court. TMPs are developed by qualified traffic management designers in accordance with the *Road Safety Act 1986*, the *Road Management Act 2004*, the *Code of Practice for Worksite Safety – Traffic Management*, and Australian Standard 1742.3 2019 *Traffic Control for Works on Roads*.
45. According to the TMP, at the time of the collision, there should have been a 15 tonne GVM Truck Mounted Attenuator (TMA), fitted with a Directional Arrow Board and Variable Message Sign (VMS) (**‘the rear TMA’**). The VMS comprised of two screens, with one image depicting the right lane was closed and the left lane was open, and the second image was a ‘ROAD WORK AHEAD’ sign. This truck was at the rear of the convoy of vehicles and was placed in the right emergency lane, adjacent to the centre grassy median strip.
46. The TMP directed that 300-500 metres (on open roads) or 200-300 metres (in built-up areas) there was a second 15 tonne GVM TMA fitted with a Directional Arrow Board and VMS (**‘the front TMA’**). The VMS was again a two-screen display with one image depicting an image of a construction worker and the second image was a ‘ROAD WORK AHEAD’ sign. The front TMA was in the right-hand lane, ahead of the rear TMA. The grass mower was located on the median shoulder, in front of the wire rope safety barrier. All three vehicles moved along the road at the same pace as part of the convoy.
47. DTP confirmed that the Fulton Hogan Crew Leader on site at the time of the collision had the required training and qualifications with respect to the implementation of the TMP. Fulton Hogan, via DTP, provided copies of the Crew Leader’s truck licence, induction card and traffic management qualification.

D/Sgt Hardiman - Supplementary statement dated 3 April 2025

48. Upon receipt of DTP’s statement, the Court provided the DTP’s statement and annexures to D/Sgt Hardiman and requested she provide a supplementary statement. Specifically, D/Sgt Hardiman was asked, in relation to the slasher operation:
 - a) Whether appropriate warning signs were in place for motorists; and
 - b) Whether there were appropriate safety measures in place to allow traffic to slow to a stop safely in light of the lane closure ahead.

Whether appropriate warning signs were in place for motorists

49. D/Sgt Hardiman noted that when she attended the scene of the collision (several hours after it occurred), the TMP and all relevant safety equipment were no longer present at the scene. She reviewed the dash camera footage of the one of the vehicles involved in the unrelated collision, behind the Fuso. From this footage, D/Sgt Hardiman noted there did not appear to be any warnings of roadside treatment/road works prior to the area of impact of either collision. Pursuant to the TMP provided, there was no requirement to have any warnings prior to the rear TMA vehicle, which was 300 to 500 metres behind the front TMA vehicle. From the evidence provided, D/Sgt Hardiman was unable to confirm that the TMP was being complied with, however noted there was no evidence to suggest that it was not being complied with.
50. D/Sgt Hardiman noted that none of the drivers involved in either collision described the VMS present on the day. One witness described a black and white sign about 500 metres on a stand displaying 'Slashing Ahead' as well as another sign which said to merge left. Ms Williams reported that the first sign she observed was on the right lane of the Princes Highway. She described it as an LED sign on a small trailer which had the word 'STOP' in red with an arrow pointing to the left. Ms Williams reported that she came to a stop behind this sign, and that there were about 10 cars between the front of her car and the STOP sign. She described being stationary for about 10 to 20 seconds before moving again. It was as she started moving again that the collision between the Fuso and the Jeep occurred.
51. D/Sgt Hardiman opined that the signed described by Ms Williams was the rear TMA, which should have been 300 to 500 metres behind the front TMA. She noted that the rear TMA should have been on the right road shoulder, and not in the travelling lane. From the physical evidence at the scene, Ms Williams was in the left lane and not the right lane when she came to a stop. D/Sgt Hardiman noted it was unclear where the rear TMA was positioned but it appears that it was either in the right lane or on the right shoulder, and not 10 vehicles ahead of Ms Williams. The recording from the back of the rear TMA vehicle depicted an 80km/h speed limit and 'ROAD WORK'. It did not display the word 'STOP' at any time.
52. Mr Loft stated that he was travelling in the right lane and observed the traffic ahead of him slowing down and merging left. He reported that he saw the merging traffic before he saw any signs. He stated that when he first saw vehicles merging left, they were about 500 metres ahead of him. He was reportedly slowing down when he observed the arrow board in the right lane, ahead of him. As he merged into the left lane, he realised that the vehicles in the left lane

were stationary and claimed that neither the merging vehicles nor the arrow sign was obscured, and he believed that the arrow sign was the only signage that he saw prior to slowing down. D/Sgt Hardiman assumed that the sign Mr Loft was referencing was the rear TMA vehicle.

53. Similarly, Samantha noted that she first recalled seeing the road work lights 150 metres ahead of her. She described the sign was on the back of a truck on the right-hand side of the road and was flashing. The sign made her consider that there was mowing in the distance, but she did not see a mower. D/Sgt Hardiman assumed that Samantha was referring to the rear TMA vehicle.
54. Considering all of the available evidence, D/Sgt Hardiman concluded that the first warning of the mowing was the rear TMA vehicle, which should have been on the right road shoulder, about 300 and 500 metres before the actual mowing. The fatal collision occurred near to, but before the rear TMA vehicle and there did not appear to be any warning signs prior to this. D/Sgt Hardiman explained that ultimately, the first sign has to be placed somewhere, and in this case, the sign on the rear TMA had a reduced speed of 80km/h and a right lane closure arrow. If the rear TMA vehicle was on the right shoulder, then the only immediate requirement from drivers would be to slow from 110 to 80km/h.
55. However, based on the area of impact, D/Sgt Hardiman opined that it was likely that the rear TMA vehicle was near the Little Moe River bridge, where the TMA must move left into the right travelling lane as there is no shoulder at that location. When the rear TMA vehicle is in the right travelling lane, the first instance the drivers became aware of the roadside treatment was when they were required to slow from 110 to 80km/h *and* also merge into the left lane, before reaching the truck. In her opinion, D/Sgt Hardiman explained that given the rear TMA vehicle was mobile and could not always comply with the plan by being on the shoulder, there should be a stationary warning sign which does not require that a driver taken any action, rather it would alert them to roadside treatment ahead, such that they will be required to modify their driving at a point in the future. D/Sgt Hardiman opined that a pre-warning sign prior to being required to take action would increase driver expectation of having to slow or move lanes, which would reduce the likelihood of a collision.

Whether there were appropriate safety measures in place to allow traffic to slow to a stop safely in light of the lane closure ahead

56. In accordance with the TMP, vehicles should not have been required to stop and were not required to stop. The speed reduction was from 110 to 80km/h, with all vehicles to move into

the left lane. The rear TMA vehicle should have been on the right shoulder, with the front TMA vehicle in the right travelling lane. If the rear TMA vehicle was on the road shoulder, in accordance with the TMP, vehicles travelling on the Princes Highway should have had 300 to 500 metres to merge left and slow to 80km/h. The left lane was never blocked by the mobile convoy, and the left lane should have been clear for traffic to flow through without having to come to a complete stop.

57. Unfortunately, if the rear TMA vehicle was forced into the right travelling lane, vehicles on the Princes Highway would be forced to merge *and* slow before the warning truck, of which they have no warning. D/Sgt Hardiman stated it was unclear why vehicles came to a complete stop in this instance; however, she noted that irrespective of the instructions given to drivers, it is very difficult to control how they respond. She further noted that driver behaviour is unpredictable and sometimes inexplicable.
58. In her opinion, D/Sgt Hardiman noted that the reason the vehicles stopped in the left-hand lane was most likely due to the very sudden lane merging that was required when the rear TMA vehicle moved left (into the right travelling lane) to cross the bridge where there was no right shoulder. Ultimately, it was the vehicles that stopped unexpectedly that led to the collision.
59. D/Sgt Hardiman noted that while it was not possible to definitively determine why the vehicles stopped, in her opinion, the perceived need to stop may have been reduced with additional static warning signs. She noted the TMP allowed for optional additional signage, which does not appear to have been utilised on this occasion. When safety measures are mobile (as they were in this case), D/Sgt Hardiman opined that additional stationary pre-warning signs would increase driver expectation and reduce the need for emergency responses.

Department of Transport and Planning – Second statement dated 31 July 2025

60. Following receipt of D/Sgt Hardiman's supplementary statement, I directed that a copy of this statement be provided to DTP and requested a supplementary statement. Specifically, DTP was asked to respond to:
 - a) D/Sgt Hardiman's opinion that a static warning sign prior to the rear TMA vehicle would have reduced the risk of drivers stopping (and this collision occurring).

- b) Whether current requirements should be amended to include mandatory additional stationary pre-warning signs to increase safety for road users.

Use of a static warning sign

- 61. DTP explained that the use of additional static advance warning signs must be carefully considered, weighing the benefits against the inherent risks associated with placing such signs in live traffic environments. DTP explained that static advance warning signs are more appropriate for worksites that are relatively stationary, where the distance between the sign and the worksite remains consistent, and continues to provide relevant guidance to road users.
- 62. In the circumstances, Fulton Hogan recommended to DTP (which DTP accepted) that the more appropriate way to address the risk of drivers stopping is to use an additional TMA, where appropriate.

Changes to the TMP

- 63. Following the incident, the TMP was reviewed by Fulton Hogan and was updated accordingly. The updated TMP came into operation in April 2025. Relevantly, the new TMP requires that consideration be given to the following controls on roads with a posted speed limit of 110km/h:
 - a) An additional TMA vehicle with on board warning signs. The third TMA will be positioned approximately 230 metres further upstream and will be located on the shoulder of the road.
 - b) Additional guidance regarding the use of a stationary VMS to provide advance notice in scenarios where the worksite remains relatively stationary or where road geometry restricts sight distance to the worksite.
 - c) For mobile operations such as mowing/slashing, the deployment of a third TMA vehicle provides advance warning, while maintaining mobility and offering increased protection to the worksite.
- 64. In relation to a constrained situation where a road shoulder is not available (as experienced here), the standard procedure undertaken by Fulton Hogan is as follows:
 - a) The rear TMA is to remain on the shoulder, while the convoy proceeds through the constrained section.

- b) Once the convoy has passed the constrained section, the rear TMA will enter the travel lane, accelerate to rejoin the convoy, and resume its position on the shoulder.
- c) This procedure minimises the duration during which the TMA operates without the protection of advance warning signage, as it is capable of travelling at a higher speed than the mobile operation.

Fulton Hogan

65. At my direction, Fulton Hogan was asked to provide a statement to the Court, outlining the following matters:
- a) The ways in which the roadside operation on 29 May 2023 was set up to be compliant with the relevant TMP applicable at the time.
 - b) How such an operation would be set up now, to be compliant with the new TMP that came into operation from April 2025, including any additional safety features that would be required.
 - c) The ways in which the April 2025 TMP demonstrates compliance with the relevant *Road Safety (Traffic Management) Regulation 2019* and *Code of Practice for Worksite – Traffic Management*.
 - d) Guidance provided to Fulton Hogan staff/contractors in the case of a critical incident, including scene safety and/or presentation.
 - e) Whether there is any current guidance regarding the appropriate times of day that are optimal to conduct mowing/slasher operations (e.g., avoiding peak hour) and whether there are any reasons mitigating against imposing time-of-day restrictions.
 - f) Noting my awareness that static warning signs would require periodic shifting for use in mobile mowing/slashing operations, explanation whether there are any reasons why static warning lights ought not anyway be required in a situation where a TMA is in operation without the protection of advanced warning signage, even if temporarily.

How the roadside operation on 29 May 2023 was compliant with the applicable TMP

66. Fulton Hogan explained that on 29 May 2023, traffic management arrangements for roadside mowing were set up in accordance with the relevant TMP, with the mower on the median shoulder area in front of a wire rope safety barrier. Two TMAs were deployed as follows:
- a) The rear TMA was located on the median shoulder to provide advanced warning of the works.
 - b) The front TMA was located in the right-hand lane of Princes Highway, closing the lane prior to the mower, to protect road users and the tractor operator.
67. Fulton Hogan explained that all three vehicles were operating in a mobile convoy.

How the roadside operation would be set up today, compliant with the new TMP dated April 2025.

How this plan is compliant with relevant legislation

68. The new TMP introduces a third TMA which provides two advanced warning TMAs located off traffic lanes (on the shoulder) prior to the front TMA vehicle which operates to both close the lane and protect both road users and the tractor/machinery operator.
69. Fulton Hogan further explained that this new TMP was developed in accordance with the risk-based approach outlined within the Austroads Guide to Temporary Traffic Management, which was adopted in Victoria as the *Code of Practice for Worksite Traffic Management* on 1 December 2023. This Traffic Guidance Scheme (TGS) was prepared by Traffic Technique Pty Ltd, a DTP accredited traffic management company. This TGS was submitted to DTP for review, in order to obtain a Memorandum of Authorisation (MoA), authorising the implementation and use of traffic control device(s) and the conduct of traffic management activities on arterial roads. DTP issued this MoA effective 25 April 2025.

Guidance provided to Fulton Hogan staff regarding critical incidents

70. Fulton Hogan explained that immediately after the fatal incident, the Fulton Hogan mowing team immediately ceased work, with both TMAs repositioning to provide advanced warning and traffic control on the approach to the incident site. The TMA operators took this approach to address the risk of further incidents and set up a safe working environment for first responders.

71. Fulton Hogan further explained that its staff are trained to preserve the scene of any serious workplace incident, where safe to do so. Staff are advised that they are permitted to take action to protect a person's health or safety, help someone who is injured, and/or make the area safe.

Imposition of time-of-day restrictions on conducting mowing/slashing operations

72. DTP recently advised Fulton Hogan (and its other maintenance contractors) of standardised MoA conditions that apply to maintenance services across Victoria's arterial road network, including mowing. Fulton Hogan noted they understood that the authorised window of time allowed for mowing activities, including lane closures, is 7.00am to 7.00pm on rural freeways/highways and arterial roads. Fulton Hogan noted it would be happy to work with DTP on any alterations to the authorised working times.

Use of static warning signs

73. Fulton Hogan explained that the purpose of the two TMAs operating on the shoulder approaching the work zone is to provide advanced warning of the works. The deployment of static traffic management signs introduces the risk of workers on foot being exposed to traffic. TMAs aim to eliminate this risk, however Fulton Hogan noted that it has since deployed a single VMS trailer on the left shoulder of the Princes Highway (specifically), to provide further advanced warning of mowing activities within the next 10km. The VMS trailer is generally required to be moved every second work shift, as 5km of shoulder mowing can usually be completed in a single shift.
74. Fulton Hogan explained that full lane closures using static traffic management signs and cones are generally limited to a 500m work zone, reducing work output to 1km per day. It explained that this is a high-risk activity, exposing workers to high-speed traffic for prolonged periods, requiring almost constant adjustment of signs and cones, as the works progress.

Other comments

75. For mowing operations where TMAs are deployed each day, the TMA can be used on the left shoulder to protect traffic controllers connecting/disconnecting VMS trailers for relocation as advanced warning of mowing works over the next 10km. This addition to mowing on Category 3, high-speed, high-volume traffic routes in Victoria is a low-cost and simple mechanism of providing advanced warning for mowing. Fulton Hogan noted it supported mandating this additional measure on all Category 3 routes.

CONCLUSION

76. I note for completeness that it is not the coroner's role to attribute blame or to apportion civil or criminal liability. However, within these bounds, it is relevant to note that there was insufficient evidence for police to charge the driver of the Fuso truck with any criminal offence, and there is no evidence before me that any other driver involved in the collision was driving in a risky or dangerous manner. These drivers simply found themselves in a situation of having to navigate – unexpectedly – changed traffic conditions on a route they were likely very familiar with and travelled most days.
77. I note there is also no evidence that the mowing operation giving rise to those changed traffic conditions was non-compliant with then-applicable standards, in relation to which I have received detailed statements from both the Department of Transport and Planning (**DTP**) and Fulton Hogan, and I do not consider that adverse comments are warranted. However, my investigation has demonstrated that there is scope to improve the safety measures underpinning the sorts of mowing operations that were being conducted at the relevant time of the collision.
78. Having considered all of the circumstances, including the responses from DTP, Fulton Hogan and D/Sgt Hardiman, I am of the view that a recommendation ought be made to DTP and Fulton Hogan, to mandate the use of single Variable Message Sign trailer on the shoulder of the road to serve as additional advance warning to motorists, prior to motorists encountering the two to three moving TMAs and the roadside operation.
79. Furthermore, I am of the view that DTP and Fulton Hogan ought to limit roadside mowing/slashing operations to ensure that they do not occur during peak traffic periods, to reduce the risk to both motorists and the roadside workers.
80. I conclude by noting that it is hard to overstate the impact of a multi-vehicle collision of this nature on those involved, some of whom were children on their way to school. It is clear to me from viewing available footage and considering statements of those involved that this day has marked their lives forever. I consider that the improved safety measures I am recommending are simple, easy to implement and will result in safer roads for people driving at peak times, and may help to avoid the future occurrence of such devastating loss of life.

FINDINGS

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

- a) the identity of the deceased was Rhiannon Charlotte Drake, born 22 September 1992;
- b) the death occurred on 29 May 2023 at Princes Highway, Nilma Victoria 3821, from head injuries sustained in a motor vehicle incident (passenger); and
- c) the death occurred in the circumstances described above.

RECOMMENDATIONS

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

- (i) That the **Department of Transport and Planning** in conjunction with **Fulton Hogan** give consideration to:
 1. Limiting hours for conducting slashing/mowing operations to avoid daily peak hour period(s); and
 2. Mandating the use of a single electronic variable messaging sign on all Category 3 routes in Victoria.

I convey my sincere condolences to Rhiannon's family, friends and loved ones for their immeasurable loss. I acknowledge the impacts of the trauma suffered by all involved in the collision, and the efforts of first responders at the scene.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) 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:

Stephen Mceachran, Senior Next of Kin

Department of Transport and Planning

Fulton Hogan

Samantha Armstrong (C/- Maurice Blackburn)

D/Sgt Janelle Hardiman

Transport Accident Commission

Detective Senior Constable Suzanne Barnes, Coronial Investigator

Signature:



Coroner Ingrid Giles

Date: 19 March 2026

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.
