IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001015

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	James Bradley Barella-Dick
Date of birth:	7 March 1988
Date of death:	20 February 2024
Cause of death:	1(a) head injury sustained in an electric unicycle accident
Place of death:	Wimpole Crescent Bellfield Victoria 3081

INTRODUCTION

1. James Bradley Barella-Dick was 35 years old when he died on 20 February 2024 after coming off his motorised unicycle (**e-unicycle**) while riding on the Darebin Creek Trail. James was an experienced and avid e-unicyclist having also ridden motorcycles for many years. He joined a group of other e-vehicle riders and was known to be highly skilled and a technically proficient rider.

2. James purchased the e-unicycle in 2023. The e-unicycle was fitted with a hub mounted motor and is gyroscopically controlled by the rider leaning forwards or backwards. James was also known for servicing a wide range of e-vehicles for others. This work included removing speed limiters to allow for greater speeds and power.

THE CORONIAL INVESTIGATION

3. James' 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 Coroner's Investigator for the investigation of James' 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.

7. This finding draws on the totality of the coronial investigation 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.

8. Finally, in the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

9. On 20 February 2024, at about 4.50pm, a witness was in their car at a stop sign waiting to turn left from Waterdale Road into Livingstone Street, Ivanhoe. The driver observed a person subsequently identified as James on his e-unicycle riding past along Livingstone Street. The driver observed James moving *"back and forwards like a slalom skier across the lane"* and described his riding as *"aggressive"*.

10. At about 5pm, an off-duty police member from the Highway Patrol Solo Unit observed a man subsequently identified as James on a motorised unicycle on the Darebin Creek Trail while walking their dog. The member thought that James was riding at speeds up to 40km/h and was using the full width of the path instead of keeping to the left.

11. Darebin Creek Trail is a shared bicycle path which runs along Darebin Creek. It primarily runs north south and has a broken white central line dividing each direction of travel. The trail is concreted and has many turns, crests, and dips along its path resulting in blind spots and blind corners. In certain sections, guard rails or retaining walls are in place for additional safety.

12. Shortly afterwards, two cyclists riding south observed James riding towards them from the opposite direction. One of cyclists stated that they ride along the trail every day and thought that James was travelling twice the speed of what they would typically observe in a cyclist travelling towards them. Both cyclists observed James coming downhill around the corner of the trail on the wrong side of the path.

13. The second cyclist stated that both they and James took evasive actions resulting in James swerving back into his lane. All parties passed each other without colliding, but both cyclists heard a loud sound soon after passing James which suggested to them that James had crashed. The cyclists turned around and observed James as having come off the e-unicycle and lying on the ground.

[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.

14. Both cyclists immediately administered first aid and one called Triple Zero. The call taker advised the cyclists to commence CPR, which they did until paramedics from Ambulance Victoria could attend.

15. Paramedics attended soon after and took over resuscitative efforts. Unfortunately, James had sustained catastrophic head injuries and could not be revived.

16. The helmet ended up some distance away from James. One of the cyclists stated that James had been wearing a helmet but provided an opinion that it must not have been fastened because of how far away it ended up. The other cyclist observed that the chin straps were undone when they saw the helmet after the incident. The other earlier witnesses also observed James wearing a helmet but did not comment on whether it was fastened. Forensic examination of the helmet did not show any patterns of damage that would usually be seen if the chin strap was fastened and fitted correctly.

17. Members from Victoria Police also attended the scene. They observed imprints along the trail of the path from the e-unicycle and sketched and photographed the scene. The prints confirmed that James crossed over to the wrong side of the path while coming around the bend before sharply correcting back to the left-hand side. The prints then showed that James had travelled directly into a barrier post before being ejected from the e-unicycle and coming to a rest approximately 7.9m away.

18. Mechanical examination of the e-unicycle by the Collision Reconstruction and Mechanical Investigation Unit of Victoria Police did not identify any faults, failures, or conditions that could have caused or contributed to the collision. There was also no evidence of tampering as all the factory tamper seals and glue were intact.

Identity of the deceased

19. On 21 February 2024, James Bradley Barella-Dick, born 7 March 1988, was visually identified by his mother, Rita Barella-Dick.

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

Medical cause of death

21. Forensic Pathologist Adjunct Associate Professor Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 21 February 2024 and

provided a written report of the findings. Adj A/Prof Parsons also considered a postmortem CT scan.

22. The examination showed significant head injuries.

23. Toxicological analysis of postmortem samples identified the presence of ethanol (alcohol) at a concentration of 0.1g/100mL. By comparison, the legal limit for driving a motor vehicle is 0.05g/100mL.

24. Adj A/Prof Parsons provided an opinion that the medical cause of death was *1(a) head injury sustained in an electric unicycle accident.*

25. I accept Adj A/Prof Parsons opinion. I also note that the significant nature of the head injuries suggests that the helmet had come off prior to the head strike.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was James Bradley Barella-Dick, born 7 March 1988;

    b) the death occurred on 20 February 2024 at Wimpole Crescent, Bellfield, Victoria 3081, from a *head injury sustained in an electric unicycle accident*; and

    c) the death occurred in the circumstances described above.

27. Having reviewed all the evidence, I find that James' death was the result of an accident while riding a motorised unicycle in a risky fashion. Excessive speed, high alcohol consumption, being on the wrong side of the path, and wearing an improperly fastened helmet contributed to the death.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments.

28. There has been a reported increase in the number of incidents of injury and death related to motorised personal mobility devices such as e-scooters and e-unicycles. According to VicRoads, these devices are defined as motor vehicles unless specifically exempted under the *Road Safety Act 1986*. VicRoads notes that in most cases, these devices do not meet the

Australian Design Rules or standards for registration so they cannot be used on roads or footpaths.[2]

29. I note ongoing public debate and government discussion around possible training and registration for these types of e-vehicles. However, I also note that James held a motorcycle licence and would not be the target demographic for, nor would he benefit from, any training relating to e-vehicle use. Further, the contributing factors in this case were speed, alcohol intoxication, riding on the wrong side of the path, and an improperly fastened helmet.

30. As such, I am not satisfied that additional training requirements or registration requirements for e-vehicles would have prevented the death in this case. James was an experienced rider who knew, or should have known of the risks of undertaking an inherently dangerous activity.

I convey my sincere condolences to James' family for their loss.

I direct that a copy of this finding be published on the internet in accordance with the Coroners Court Act s 73(1A).

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

Rita Barella-Dick, Senior Next of Kin

Signature:

Coroner Katherine Lorenz

Date : 30 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.

[2] https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/a-to-z-of-road-rules/hoverboards-segways-and-other-motorised-devices. Accessed 5 July 2024.