IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001841

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Vignesh Choudary Khilari
Date of birth:	6 March 2004
Date of death:	31 March 2024
Cause of death:	1a: Head, chest, pelvic and leg injuries sustained in a motor vehicle incident (motorcycle vs. Electricity pole)
Place of death:	Warrigal Road Oakleigh Victoria 3166

INTRODUCTION

1. On 31 March 2024, Vignesh Choudary Khilari was 20 years old when he died in a motorcycle collision. At the time of his death, Vignesh lived in Rowville with his parents and older brother.

2. Vignesh held a probationary car license, obtained on 15 November 2022. On 12 November 2023, he and his father obtained their motorcycle learner permit.

3. At the time of the collision, Vignesh was riding a Honda CBR650 motorcycle, registered to his father. The motorcycle had a capacity of 560cc, which is the highest capacity for a learner approved motorcycle.

THE CORONIAL INVESTIGATION

4. Vignesh'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.

5. 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.

6. 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.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Vignesh's death. The Coronial 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.

8. This finding draws on the totality of the coronial investigation into the death of Vignesh Choudary Khilari 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]

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

Circumstances in which the death occurred

9. On the evening of 31 March 2024, Vignesh attended a car meet held in the carpark of Bunnings in Oakleigh South.

10. Police attended the meet and observed more than 500 vehicles, including cars and motorcycles. They noted *'it was a very busy scene with cars and bikes coming and going and pedestrians everywhere'* and *'I could hear lots of loud revving and erratic driving in and around the area.'* Organisers of the event told police that most attendees behaved well within the meet itself, but there was regular hoon-like behaviour from attendees leaving the event.

11. At around 9:10pm, Vignesh left the meet with a group of motorcycle riders, intending to ride to Daniel's Donuts in Springvale. He turned right from the Bunnings carpark onto Warrigal Road to travel northbound. As he accelerated on the straight, he opened the throttle with a loud rev of the engine. He then lost control of his motorcycle and veered to the left-hand side of the road around 120 metres from the carpark exit. His motorcycle became airborne after hitting the curb, and Vignesh collided with a power pole. His motorcycle came to rest some 30 metres from the point of impact.

12. Several witnesses including an off-duty nurse stopped to render assistance to Vignesh, including administering CPR. He was unable to be revived and was declared deceased by paramedics at 9:45pm.

13. Vignesh was not wearing any protective clothing at the time of the collision, nor was he displaying an L plate or wearing a high-visibility vest, in contravention of his learner permit conditions.

[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. Detective Senior Constable Sandeep Singh Chauhan of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit analysed the collision and calculated that at the time of impact, the minimum speed range of Vignesh's motorcycle was 55 to 65 km/h.

15. There was no suggestion that a mechanical fault of the motorcycle may have caused or contributed to the collision.

Identity of the deceased

16. On 3 April 2024, Vignesh Choudary Khilari, born 6 March 2004, was visually identified by his father, Sreenivasa Khilari, who completed a Statement of Identification.

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

Medical cause of death

18. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Vignesh Khilari on 2 April 2024. Dr de Boer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and scene photographs and provided a written report of his findings dated 24 April 2024.

19. The external examination and post mortem CT scan showed multiple and traumatic injuries in keeping with the known circumstances.

20. Toxicological analysis of post mortem blood samples identified the presence of delta-9-tetrahydrocannabinol (~ 4 ng/mL).

21. Dr de Boer provided an opinion that the medical cause of death was 1(a) HEAD, CHEST, PELVIC AND LEG INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (MOTORCYCLE VS. ELECTRICITY POLE).

CORONERS PREVENTION UNIT REVIEW

22. Coronial Investigator Nicole Thomas made suggestions for improvement to the motorcycle licensing regime, including:

    - Incorporating a defensive riding course after three months of riding and prior to obtaining a full license;

- A requirement for a certain number of hours to be logged, as per a car learner's permit; and

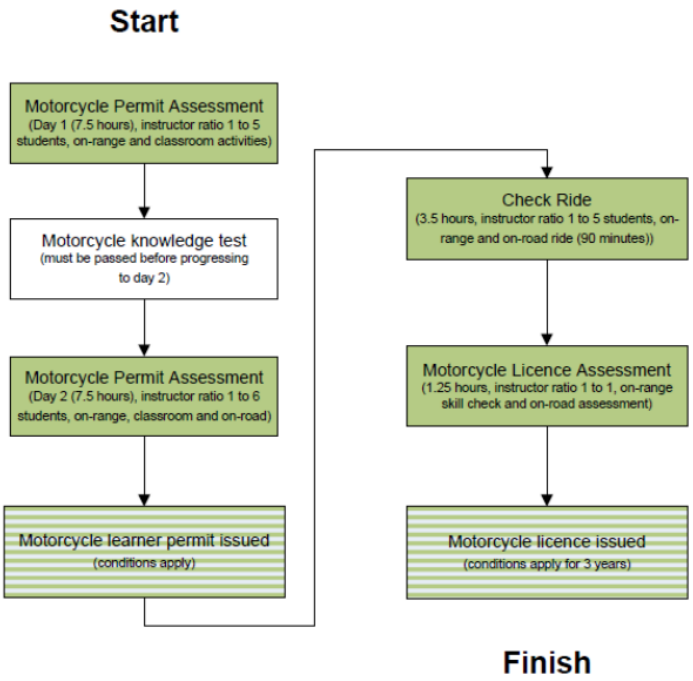
- An additional third day of the learner's course to work on skills in a controlled environment including higher speed roads and navigating traffic and intersections.

23. I requested that the Research and Policy team of the Coroners Prevention Unit (**CPU**)[2] advise me as to the number of deaths of learner motorcyclists in Victoria, whether previous recommendations have been made to improve safety for learner motorcyclists, and whether any recommendations could be made to improve safety.

24. The CPU identified 709 motorcycle fatalities in Victoria between 1 January 2010 and 30 June 2025. Of these, 36 people (other than Vignesh) were confirmed to hold a learner permit at the time of the fatal incident. A review of the available coronial findings did not identify any relevant comments or recommendations regarding motorcycle licencing for learners.

Overview of Victoria's current motorcycle licensing system

25. In 2016, Victoria introduced a graduated licence system for motorcycle licences:



[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

26. The initial two-day learner course[3] includes, on day one: basic riding skills, how to use the controls, how to get moving, stop, turn and change gears, a discussion on the unique aspects of motorcycling, an introduction to roadcraft tactics, what to look for when buying riding gear and a motorcycle knowledge assessment.

27. Day two includes slow speed manoeuvring skills, steering and cornering, emergency braking, strategies for safe riding, a simulated road ride and an on-road assessment.

28. The 'check ride'[4], a half-day coaching course, is required to be completed at least one month before the provisional licence assessment. It includes:

    - an off-road review of braking, steering and low-speed manoeuvring skills
    - an on-road coaching ride on a pre-determined route.

29. The check ride involves riding on multi-lane highways, narrow country roads, shopping centres, and hills and bends and is completed with a group of up to five other riders. The instructor will:

    - provide feedback on the ride
    - discuss practical ways to reduce the risk of crashing.

30. Before a provisional licence can be obtained, a rider also needs to pass a motorcycle licence test, which involves being assessed for a licence in off-road and on-road tests:

    - The off-road test checks the riders' ability to safely control a motorcycle. This includes a controlled stop, sharp left turn, slow ride, change of path, safe path through a curve, and quick stop.
    - The on-road test checks observations skills (head checks, turning at intersections, changing lanes), safe speed choice, and lane position (buffering).

Assessment of suggested recommendations

[3] Transport Victoria, "Get your motorcycle Ls", < https://transport.vic.gov.au/road-and-active-transport/registration-and-licensing/licences/motorcycle-licence/get-your-motorcycle-ls>.

[4] Transport Victoria, "Prepare for your motorcycle licence", <https://transport.vic.gov.au/registration-and-licensing/licences/motorcycle-licence/prepare-for-your-motorcycle-licence#h2-c005h>.

31. The CPU also liaised with an expert in the field, Professor Teresa Senserrick, Director at the Western Australia Centre for Road Safety Research. Prof. Senserrick offered the following observations with regard to Senior Constable Thomas' suggestions:

Incorporating a defensive riding course after three months of riding and prior to obtaining a full license

32. *The 'Check Ride' course is a truly 'defensive' course, where individuals receive on-road coaching. Some off-road/track courses labelled 'defensive' in fact teach advanced driving skills. While this might seem logical, they inevitably lead novices to believe they are more capable than they actually are – what is known as 'miscalibration' or 'over-confidence' – and results in increased crashes. The Check Ride program addresses this by giving individual and group feedback that demonstrates safer rising tactics while impressing upon riders that truly safe instinctive skills can only fully be developed over time as they gain more riding experience.*

A requirement for a certain number of hours to be logged, as per a car learner's permit

33. *It is critical not to compare the motorcycle learner period with the car licence learner period. Supervised learning in a car is one of the safest times of driving which transitions to the highest risk when first driving unsupervised. Learner riders face this extreme risk immediately. Even if a supervisory rider is with them (and there is some evidence that this is not safe, particularly for the supervisory rider), their capacity to assist the learner does not match that of a driving supervisor who essentially has a similar view of the road to assist with 'co-driving', can talk to the learner in 'real time' and can take over some controls if needed (steering wheel and hand brake). None of this generally applies to an accompanying rider with the added issue of road surface being very critical for riders to monitor for things like oil slicks and painted lines that are not a major issue in a car. Riding side-by-side is not recommended therefore as then there is no chance to move around in the lane for such hazards. Learner riders tend to gain riding experience at a pace they feel comfortable with, and for many this is very few hours and very low riding at night, in poor weather or in complex environments, for example. As such, mandating hours would be counterproductive by increasing risky exposures among the cohort over and above what occurs naturally.*

An additional third day of the learner's course to work on skills in a controlled environment including higher speed roads and navigating traffic and intersections.

34. *Victoria's two full day limit on the motorcycle licence course for learner licensure was set to keep candidate costs somewhat equivalent to gaining a driver licence (allowing for an average of 10 professional lessons). This is the longest such course in Australia.*

COMMENTS

Pursuant to section 67(3) of the *Coroners act 2008*, I make the following comments in relation with the death:

1. I accept the observations of Prof. Senserrick and consider that Victoria's motorcycle licensing system is largely fit for purpose in its current form and is also in the process of being reviewed.

2. I note that the Victorian government has explicitly acknowledged the vulnerability of motorcycle riders, with motorcycles representing 3.3% of all registered vehicles yet comprising 18.4% of lives lost during 2019-2023.[5]

3. Victoria's *Road Safety Action Plan 2* (published in December 2024) states that the Department of Transport and Planning are reviewing the Motorcycle Graduated Licensing System *'to improve outcomes for the motorcycling community'.*[6]

4. In addition, the statewide Motorcycle Safety Framework is expected to be released this year, which will provide a suite of coordinated and targeted countermeasures aimed at reducing motorcycle fatal and serious injury crashes.[7]

5. I am hopeful that these initiatives will go some way to reducing the disproportionate and frankly excessive number of motorcyclist deaths in Victoria.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Vignesh Choudary Khilari, born 6 March 2004;

    b) the death occurred on 31 March 2024 at Warrigal Road, in the vicinity of the intersection with Centre Road, Oakleigh Victoria 3166;

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[5] Victorian Government, *Victorian Government response – Parliamentary inquiry into the impact of road safety behaviours on vulnerable road users*, Melbourne: Victorian Government, March 2025.

[6] Victorian Government, *Road Safety Action Plan 2*, Melbourne: Department of Transport and Planning, 2024.

[7] Victorian Government, 'Current projects – Motorcycle Safety Levy', <https://www.vic.gov.au/current-projects-motorcycle-safety-levy>, updated 10 June 2025, accessed 30 July 2025.

c) I accept and adopt the medical cause of death ascribed by Dr Hans de Boer and I find that Vignesh Choudary Khilari died from head, chest, pelvic and leg injuries sustained in a motorcycle collision;

2. AND, having considered the available evidence, I find that Vignesh Choudary Khilari's relative inexperience at motorcycle riding was the main contributing factor to the collision. In addition, while I am unable to assess the degree to which the cannabis detected at toxicology contributed to his actions, I find that his decision to ride having consumed cannabis and without the requisite safety gear is evidence of his risk-taking behaviour.

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 convey my sincere condolences to Vignesh's family for their loss.

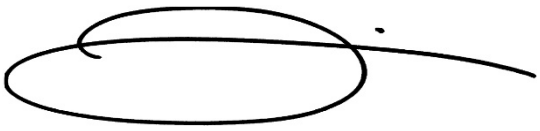
I direct that a copy of this finding be provided to the following:

Sreenivasa and Chandana Khilari, Senior Next of Kin

Transport Accident Commission

Senior Constable Nicole Thomas, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 7 October 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.