IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003551

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Grant Jason Dimitrijevic
Date of birth:	18 August 1983
Date of death:	01 July 2023
Cause of death:	1a : COMPLICATIONS OF A RIGHT UPPER ARM PENETRATING INJURY IN THE SETTING OF A MOTOR VEHICLE INCIDENT (DRIVER)
Place of death:	785 Hendy Main Road, Moriac, Victoria, 3240
Keywords:	Motor vehicle incident, livestock wandering on public road

INTRODUCTION

1. On 01 July 2023, Grant Jason Dimitrijevic (**Grant**) was 39 years old when he died in a motor vehicle incident. At the time of his death, Grant lived at 17 Islington Place, Caroline Springs, Victoria, 3023 with his wife, Sarah Dimitrijevic (**Sarah**) and their two children.[1]

Background[2]

2. A keen sportsman, Grant and Sarah first became friends in 1996 through their sporting activities. According to Sarah, their respective families 'were heavily involved in softball and sports'. In later years, Grant became his son's 'U9' team's 'Football Coach'.

3. Around 2004, the couple entered a relationship, started to build a house and 'moved in together'. In 2012, they moved to the home which Grant occupied with his family at the time of his death.

4. Over the years, Grant worked as a truck driver for various employers. From 2005 to 2015, he 'had his own business' called 'GSD Haulage'. In addition to working as a truck driver, Grant took up casual employment in 'landscape and gardening'. According to Sarah, her husband 'always did casual jobs to keep the cash flowing in for the family'.

5. From about June 2023, Grant was employed at 'Titan Premix' as a truck driver.

Health concerns

6. The available evidence indicates that Grant did not have any major health concerns. According to Sarah, her husband led an active lifestyle 'playing softball' for a club and coaching other football and softball teams.

7. Throughout his life, Grant was a non-smoker. He did, however, enjoy a 'social drink on the odd occasion with friends or family'. Sarah described her husband as a 'selfless and hard worker' who provided well for his family. Grant was her 'best friend' and a 'great dad' to their children'.

[1] Coronial Brief of Evidence [**CB**], Statement of Sarah Dimitrijevic.
[2] Ibid.

THE CORONIAL INVESTIGATION

8. Grant'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Grant'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.

12. This finding draws on the totality of the coronial investigation into the death of Grant Jason Dimitrijevic 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.[3]

[3] 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.

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

Circumstances in which the death occurred

13. On 30 June 2023, Grant enjoyed dinner with his family at the local shopping centre and planned to take his son 'to the footy' on the following day. The evidence indicates that Grant's outing to 'the footy' with his son, was scheduled for after his day at work.

14. On 1 July 2023 at approximately 6.12 am, William Kenyon (**Mr Kenyon**) was driving along Hendy Main Road, Moriac, on his way to work, when he observed the vehicle ahead of him slowing down. As he got closer, Mr Kenyon 'saw a black cow on the road which appeared to have been hit'. The cow 'wasn't alive' and appeared to have been struck by a vehicle.[4]

15. When Mr Kenyon 'looked to the right' he observed 'a white truck' which was 'off the road and into the trees'. As Mr Kenyon parked his vehicle on the left side of the road to take a closer look, his colleague also stopped. Together, they 'ran over towards the truck' and observed a 'smashed window' and 'a heap of branches'. The passenger side door was open but Mr Kenyon did not find anyone inside the truck's cabin which he described as 'pretty messy'.

16. On further inspection, Mr Kenyon and his colleague discovered who they later ascertained was the driver of the truck in a foetal position on the ground next to the tyre bar which was supporting him'. According to Mr Kenyon, the driver was 'not in good shape' and was making 'moaning/groaning sounds'. Mr Kenyon described the driver as someone who was 'trying to breathe'.[5]

17. During this time other road users also stopped to render assistance. Mr Kenyon asked one of the passers-by to 'call for an ambulance'. At approximately 6.32 am, Victoria Police and Ambulance Victoria (**AV**) paramedics arrived at the scene.

18. According to AV paramedic, Woody Bucci, on his arrival at the scene he 'saw bystanders performing effective CPR to the patient on the roadside'. However, when he examined the person upon whom cardiopulmonary resuscitation (**CPR**) was being performed, he discovered that the patient was 'pulseless and not breathing'.[6]

[4] CB, statement of William Kenyon.
[5] Ibid.
[6] CB, statement of Woody Bucci.

19. At 6.49 am, AV paramedics declared the patient deceased.[7]

20. In their preliminary investigations, Victoria Police established that the patient was Grant Dimitrijevic.[8]

21. In their ensuing investigations, Victoria Police observed that the road was damp and it 'was still dark'. Victoria Police noted further that 'foggy' conditions prevailed which affected visibility even further. A 'black Bovine Steer' (sic) was on the side of the road. Further up the same road, Victoria Police 'observed another loose Bovine Steer walking across the road'.[9]

22. Attending Victoria Police officers then informed the Victoria Police Major Collision Investigation Unit (**MCIU**) about the incident.

23. According to Mr Kenyon, on the day before the incident, he encountered livestock wandering in the same area along that stretch of Hendy Main Road, Moriac. Subsequent Victoria Police investigations revealed numerous reports on social media platforms where community members forewarned road users about livestock wandering in the area.

Identity of the deceased[10]

24. On 4 July 2023, Grant Jason Dimitrijevic, born 18 August 1983, was visually identified by his wife, Sarah Dimitrijevic, who signed a formal Statement of Identification.

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

Medical cause of death[11]

26. Forensic Pathologist Dr Mary Francis of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 5 July 2023 and provided a written report of her findings dated 5 January 2024.

27. In the execution of her duties, Dr Francis considered the following source documents:

    i. Victoria Police Report of Death, *Form 83*;
    ii. Post-mortem computed tomography (**CT**) scan;
    iii. Scene photographs; and

[7] CB, statement of AV paramedic, Warren Cato and Victoria Police Traffic Incident System (**TIS**) Incident Report.
[8] CB, statement of Senior Constable Matthew Richards.
[9] CB, statements of Senior Constable Matthew Richards and Sergeant Patrick Brady.
[10] CB. Statement of Identification.
[11] CB, Medical Examiner's Report.

iv. VIFM toxicology Report.

28. The post-mortem examination revealed a penetrating injury of the right upper arm with a complete transection of the right axillary artery. Dr Francis commented that the 'mechanism of death' is 'exsanguination due to the transection of the axillary artery'. Dr Francis did not identify any 'significant natural disease' or any other 'significant injuries' at autopsy.

29. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.[12]

30. Dr Francis provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF A RIGHT UPPER ARM PENETRATING INJURY IN THE SETTING OF A MOTOR VEHICLE INCIDENT (DRIVER).

INVESTIGATIONS

Victoria Police investigations

31. Victoria Police including members of their MCIU investigated the circumstances in which the incident occurred which led to Grant's death. The vehicle was identified as Kenworth T610SA Heavy Vehicle, registered to Grant's employer in Riddells Creek.[13]

32. Victoria Police investigations revealed that the 'posted speed limit' in the area where the incident occurred is 100 km/h and that the road 'is surrounded by rural farmland with livestock in the paddocks'. The investigation revealed further that the dead 'cow' along the side of the road had been 'struck by the truck'. The evidence indicated that after the animal had been struck, 'the truck (. . .) lost control' and 'veered into the trees with the branches impacting the cabin'.[14]

33. Victoria Police did not identify that mechanical failure, fatigue, alcohol or drugs contributed to the incident in which Grant's death occurred. The investigation did, however, reveal that Grant was not wearing a seatbelt at the time of impact with tree when he was 'impaled by a tree branch'.[15]

[12] CB, Toxicology Report of Jessica Fernandez, VIFM Toxicologist, dated 17 July 2023.
[13] CB, Victoria Police TIS Incident Report.
[14] CB, statement of Sergeant Patrick Brady.
[15] CB, Victoria Police TIS Incident Report.

Victorian WorkCover Authority (**WorkSafe**) investigations

34. The available evidence did not indicate that Grant's own employment related duties had contributed to or were connected to his death.

35. However, given that Grant's death occurred in an area surrounded by rural farmland and, moreover, that the evidence indicated that the incident was precipitated by livestock wandering onto the roadway, WorkSafe commenced an investigation into the circumstances under which the cow had escaped from what appeared to be a commercial farm.

36. In the course of their investigation, although WorkSafe was unable to confirm ownership of the animal which had been struck by the vehicle driven by Grant at the relevant time, they established which paddock the cow may have come from and focused their investigation on the relevant premises.

37. Under the *Occupational Health and Safety Act 2004 (Vic)*, WorkSafe is empowered to investigate workplace related incidents if a 'reasonable belief' can be established that the relevant premises is a 'workplace or that there was an immediate risk to the health or safety of a person arising from the conduct of an undertaking at the premises'.[16]

38. The investigation revealed that the relevant premises was registered as a Discretionary Trading Trust and WorkSafe was unable to establish that the premises was being operated as a business. Ultimately, WorkSafe was unable to exercise its statutory powers because a 'reasonable belief' that the premises was a workplace with employees could not be established.

39. Given the outcome of the Victoria Police and WorkSafe investigations into the circumstances within which Grant's death occurred and, moreover, given my own duty to contribute to a reduction in the incidence of preventable deaths in Victoria, the numerous reported incidents of livestock wandering along that specific stretch of Hendy Main Road, Moriac, raised my concern. The evidence indicates further, that at the time when the incident occurred, there was at least one other cow wandering along the road. In my view, given the factual matrix within Grant's death occurred, wandering livestock on Hendy Main Road, Moriac, presented inadvertent risk of harm to passing motorists. Consequently, I resolved to interrogate this aspect further.

[16] CB, statement of Richard Spence, WorkSafe Inspector.

FURTHER INVESTIGATION

40. At my direction the Coroners Prevention Unit (**CPU**) reviewed the circumstances within which the death occurred focusing on the incidence of reports to the local council of livestock wandering along Hendy Main Road and the action taken by the local council to abate the risk of harm or danger the livestock posed to passing motorists or road users.[17]

41. At my further direction, the CPU obtained statistics on non-fatal incidents along Hendy Main Road, Moriac, for my consideration.

CPU review

42. In the execution of their duties, the CPU accessed the Victorian Department of Transport and Planning's (**DTP**) "Victorian Road Crash Data" which contained detailed information about road crashes and associated injuries across Victoria since 1 January2012. This information is collated from various sources including Victoria Police reports and hospital injury data.[18]

43. To expedite my inquiry, the CPU focused on a 3km straight stretch of Hendy Main Road, Moriac, in the vicinity of where the incident occurred and using the relevant GPS coordinates for the location, the CPU determined that there were no non-fatal collisions in that area since 1 January 2012. The CPU determined further that Grant's death was only fatal incident which occurred in the area since 1 January 2012.

44. With regard to reports of wandering livestock in the area, the CPU ascertained that between 1 January 2019 and 1 July 2023, the local council, Surf Coast Shire Council (**SCSC**), received six related complaints and following their own enquiries, the SCSC issued a Notice to Adequately Confine Livestock in three instances. The SCSC informed me further that VicRoads is the authority responsible for monitoring wandering livestock along that particular stretch of Hendy Main Road, Moriac.

45. Given that Grant's death was the only fatal incident during the period under review and that there were no non-fatal incidents reported during the same period and further, that the SCSC

[17] 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.

[18] CB, DataVic, "Victoria Road Crash Data", updated 18 January 2024, https://discover.data.vic.gov.au/dataset/victoria-road-crash-data ,accessed 24 January 2024.

had taken action to abate the risk of harm to the public posed by livestock wandering along the road, the CPU was unable to identify any opportunities for prevention.

46. However, having ascertained that VicRoads is the authority responsible for the management of livestock wandering along this portion of Hendy Main Road, Moriac, on 14 August 2024, by directed statement request, I sought further pertinent information from the DTP to advance the coronial investigation.[19]

DTP response

47. Acknowledging that, pursuant to section 37 of the Road Management Act (**RMA**), the Head of Transport for Victoria (**TfV**) is responsible for the management of the portion of Hendy Main Road, Moriac, where the incident occurred, DTP informed me of the processes deployed to facilitate maintenance and management of the roads under their control.

48. According to the DTP, the location where the incident occurred is subject to routine inspections under the Head of TfV, TfV's Road Management Plan (**RMP**) and section 750 of the Routine Maintenance Performance Based Specification of the Victorian Road Maintenance Contract (**the Specification**). The Specification serves as a technical reference guide for contractors and outlines the contractors' obligations, the standards they are expected to achieve, how to handle emergencies and how and when to conduct hazard inspections.[20]

49. Further, section 750.O.9(a)(iii) of the Specification obligates the contractor to manage reports of stray animal along the road, to cause the removal of stray animals along the road and to report incidents of stray animals to DTP's Traffic Operations Centre. Further, contractors are required to implement measures including the installation of appropriate signage where stray animals are encountered to manage the traffic and to mitigate any associated risks to road users. The Traffic Operations Centre did not, however, hold any records of reports of any incidents of wandering livestock on Hendy Main Road, Moriac, between 24 July 2019 and 3 March 2021.

50. I have reviewed the response of the DTP to my queries, and I note that the responsibility to investigate reports of wandering livestock and to take appropriate action to abate associated

[19] CB, *Form 4* Request for a Document or Statement.
   i. Statement questions were formulated with the assistance of Victoria Police Coronial Support Unit (**PCS**U).
   ii. On 1 July 2019, following a restructure, all functions of VicRoads were transferred to the DTP with the exception of VicRoads' registration and licensing functions.

[20] CB, DTP statement dated 10 October 2024.

risks to road users is outsourced to contractors as provided for in the relevant regulatory framework as set out above. Further, having reviewed the response of the DTP, in the context of the available evidence, I am satisfied that the measures in place to abate the risk of harm to road users by livestock wandering along Hendy Main Road, Moriac, are reasonable in the circumstances.

51. However, given the numerous historical reports on social media platforms, action taken by the SCSC by issuing a Notice to Adequately Confine Livestock in three instances and, moreover, given that the evidence indicates that at least one other cow was wandering the area at the time of the incident, I am satisfied, to the applicable standard—*on the balance of probabilities*, that wandering livestock continue to pose inadvertent risks to road users in the area, despite past efforts of the SCSC to curtail the problem posed by wandering livestock and further, despite the measures adopted by the DTP to ensure that incidents of wandering livestock are reported and dealt with in a timely manner. The evidence indicates that the DTP did not know about the WorkSafe investigation in this matter and the action taken by the SCSC when they issued the three notices relating to wandering livestock.

52. In my view, given that the SCSC and WorkSafe had investigated reports of livestock wandering in the area around the time when the incident occurred which led to Grant's death, a possible issue to consider is that there may be a lack of communication mechanisms between the relevant authorities where issues related to wandering livestock arise in the area.

53. Accordingly, I make the following apposite recommendation.

RECOMMENDATIONS

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

1. In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that the Department of Transport and Planning collaborate with all the relevant stakeholders and/or authorities to develop reporting or information sharing mechanisms when any of the stakeholders and/or authorities receive or are investigating reports of wandering livestock in the Moriac area.

2. I now make pertinent findings in this matter.

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 Grant Jason Dimitrijevic, born 18 August 1983;

b) the death occurred on 01 July 2023 at 785 Hendy Main Road, Moriac, Victoria, 3240.

c) I accept and adopt the medical cause of death as ascribed by Dr Francis and I find that Grant Jason Dimitrijevic died from the complications of a right upper arm penetrating injury in the setting of a motor vehicle incident in circumstances where he was the driver.

2. Having considered the factual matrix of this matter, I am satisfied that the weight of the available evidence supports a conclusion that wandering livestock along Hendy Main Road, Moriac, is connected with or had contributed to the motor vehicle incident in which Grant Jason Dimitrijevic's death occurred. Accordingly, I find that Grant Jason Dimitrijevic's death was the unintended consequence of the inability to take evasive action to the inadvertent risk or danger posed or presented by the livestock wandering along Hendy Main Road, Moriac, in a timely manner which caused the motor vehicle he was driving to veer off the road and collide with the tree(s) along the verge of Hendy Main Road, Moriac.

3. However, having considered all the evidence, I am satisfied that the available evidence is not sufficiently cogent to enable me to determine how the livestock wandering along Hendy Main Road, Moriac, at the time relevant and material to this matter, came to be on the road. Similarly, the available evidence is not sufficiently cogent to enable me to determine where the particular animal struck by the vehicle driven by Grant Jason Dimitrijevic immediately before the collision with the tree(s) had come from. Consequently, I find that Grant Jason Dimitrijevic's death was a tragic accident, and I make no adverse findings against or comments about any person or entity.

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

Pursuant to section 73(1B) 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:

Sarah Dimitrijevic, Senior Next of Kin

Victorian WorkCover Authority

Surf Coast Shire Council

Department of Transport and Planning

Transport Accident Commission

Senior Constable Matthew Richards, Coroner's Investigator

Signature:

Coroner John Olle
Date: 19 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.