IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 005732**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Simon McGregor |
| Deceased: | Stefan Andrew Barthelot |
| Date of birth: | 6 November 1998 |
| Date of death: | 29 September 2024 |
| Cause of death: | 1a: MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER) |
| Place of death: | Healesville - Koo Wee Rup Road<br>Yellingbo Victoria 3139 |
| Keywords: | Motor vehicle incident; collision; road conditions; speed limit. |

## INTRODUCTION

1. On 29 September 2024, Stefan Andrew Barthelot was 25 years old when he died in a motor vehicle accident. At the time of his death, Stefan lived in Berwick with his sister, Stacy Barthelot.

2. Stefan was born in Colombo, Sri Lanka and migrated to Australia in July 2019 on a student visa. Stefan was joined by Stacy in Australia in August 2023. Stefan worked as a motor mechanic in Beaconsfield.

3. Stefan was in good health with no known mental health conditions. He held a full Victorian driver's license with no substantial driving history offences recorded. He often went for long drives, including 'mountain runs', where he would drive around a mountain with no planned route.

## THE CORONIAL INVESTIGATION

4. Stefan'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 Leading Senior Constable Gareth Curran to be the Coronial Investigator for the investigation of Stefan'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 Stefan Andrew Barthelot 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]

9. In considering the issues associated with this finding, I have been mindful of Stefan's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

### Circumstances in which the death occurred

10. On 29 September 2024 at around 4:40 pm, Stefan was driving his Toyota sedan heading southbound along Healesville - Koo Wee Rup Road in Yellingbo. As he approached a left-hand bend, evidence suggests that he lost control of his vehicle which crossed over the north bound lanes and impacted a concrete power pole.[2]

11. The force of the collision caused major damage to Stefan's car and he was trapped inside the vehicle. Another road user, Ms Andrea Decker, drove past the collision site and contacted emergency services. Ms Decker had not seen the collision but was driving past the scene and saw Stefan's car significantly damaged.[3]

12. Ambulance paramedics arrived around 4:45 pm but despite their best efforts, they were unable to resuscitate Stefan. Stefan was pronounced deceased at 6:30 pm.[4]

### Identity of the deceased

13. On 1 October 2024, Stefan Andrew Barthelot, born 06 November 1998, was visually identified by their sister, Stacy Barthelot.

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

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[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.
[2] *Coronial Brief,* Statement of Detective Sergeant Jenelle Hardiman.
[3] *Coronial Brief,* Statement of Leading Senior Constable Gareth Curran.
[4] Ibid.

**Medical cause of death**

15. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 1 October 2024 and provided a written report of her findings on the same day.

16. The external examination of the body confirmed multiple and extensive injuries in keeping with the traumatic injuries evidenced on post-mortem CT scans. The injuries were of a nature that would have caused rapid unconsciousness and death. These injuries are not survivable.

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

18. Dr Fronczek provided an opinion that the medical cause of death was 1(a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT (DRIVER) and I accept her opinion.

## COLLISION INVESTIGATION

**Victoria Police**

19. Police arrived on scene at around 5:03 pm on the day of the collision and began processing the scene.

20. Coronial Investigator Leading Senior Constable Curran conducted an inspection of the vehicle and found that the vehicle had various modifications to the air intake system making it un-roadworthy. He also noted that the tyres were past the tread wear indicators.[5]

21. LSC Curran provided an opinion that *"the road surface, the tyres on the vehicle and speed were contributing factors to [Stefan] losing control of the vehicle prior to it colliding with the power pole."*[6]

22. A Victoria Police collision reconstruction specialist reviewed the available evidence and noted that:[7]

    a) Stefan was licensed and his vehicle was registered at the time of the fatal collision.

[5] Ibid.
[6] Ibid.
[7] *Coronial Brief,* Statement of Detective Sergeant Jenelle Hardiman.

b) There was evidence of unroadworthy modifications to Stefan's car including the air intake system and the tires were past the tread wear indicators making them unroadworthy.

c) The road conditions were wet but visibility was good. The speed limit on the relevant section of the road was 100km/h.

d) The bitumen was in fair condition with evidence of bitumen bleed, polishing and minor water pooling, which can affect the road surface friction levels and may affect vehicle handling.

e) The road had small craters, but no major potholes were found that would have contributed to losing vehicle control.

f) Stefan's car had an electronic crash monitoring system that provided data indicating the crash speed was approximately 101 km/h (4.1 second prior to impact) and then 106 km/h (3.1 seconds prior to impact) and 72 km/h (0.1 seconds before impact). The trigger event (actual impact) indication was 51 km/h. There is no evidence that the driver applied braking at any time in the 4.1 seconds to impact.

23. The crash collision reconstruction specialist formed the opinion that *"the Toyota was travelling southwest on the Healesville – Koo Wee Rup Road in Yellingbo at around 100 km/h when the driver lost control of the vehicle. The vehicle rotated anti-clockwise, in yaw and being led by its driver's side as it continued off the road and impacted a pole. At impact, the vehicle was travelling between 45 km/h and 71 km/h."*[8]

**Expert opinion – Dr Shane Richardson**

24. Stefan's family commissioned a report from Dr Shane Richardson, Principal Forensic Engineer, Managing Director and Owner of Delta V Experts. Dr Richardson's report was subsequently provided to the Court as part of the family's submissions.

25. Dr Richardson is an experienced mechanical engineer with extensive experience in analysing motor vehicle collisions. In producing his report, he reviewed the available material and background information, attended the collision scene and surveyed same with a handheld 3d scanner, and developed and evaluated a computed model of the collision circumstances.

[8] Statement of Detective Sergeant Jenelle Hardiman.

26. Dr Richardon's report provided comprehensive expert commentary on bitumen road construction, yaw, bitumen bleeding and its impact on friction. I have considered his report in full.

27. Dr Richardson opined that Stefan's vehicle was travelling at approximately 100km/h to 106km/h in the period 3 – 4 seconds before impact, and estimated that the vehicle impacted with the power pole at approximately 46km/h to 70km/h.[9]

28. Dr Richardson considered that the effective friction of the roadway where Stefan lost control of the vehicle was most likely below the VicRoads Skid Resistance Levels detailed in VicRoads Technical Note TN110. In his opinion, this was the most likely key contributing factor to the collision. He considered that the speed limit at the bend should have been reduced and opined *"if warning signs, reduced speed limit and/or pressure washing of the road had occurred it is possible that [Stefan] would have been travelling slower and would not have lost directional control of his Toyota."*[10]

29. Dr Richardson also noted LSC Curran's assertion that Stefan's tyres were unroadworthy. He stated that no measurements were provided to support this assertion. He reviewed photographs of the tyres and accepted that on one tyre there was edge wear, but it was not possible to confirm whether it was worn to the tyre wear indicators.[11]

30. Dr Richardson's report included statements from local road users who indicated that the road was in unsafe condition. A local resident who lives at the location of Stefan's collision stated, *"Since living here, I have never been so terrified of roads in all my life, given the poor condition and ridiculous speed limits imposed on narrow roads with tight bends and multiple driveway entries."*[12]

**SUBMISSIONS**

31. Stefan's family made written submissions in this investigation, in which they stated they largely agreed with the conclusions of investigating police members, save for the assertion that inadequate tread on the tyres was a contributing factor. They stated there was insufficient

[9] Report of Dr Shane Richardson dated 20 August 2025.
[10] Ibid.
[11] Ibid.
[12] Ibid.

evidence to conclude that the tread was inadequate; no measurements were taken of the tread to confirm whether it was worn past the tread indicators.

32. Stefan's family submitted that the road surface, speed limit and lack of signage were key contributing factors to the cause of the collision.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stefan Andrew Barthelot, born 6 November 1998;

    b) the death occurred on 29 September 2024 at Healesville - Koo Wee Rup Road, Yellingbo, Victoria, 3139, from multiple injuries sustained in a motor vehicle incident (driver); and

    c) the death occurred in the circumstances described above.

34. Having considered all of the evidence, including the report of Dr Shane Richardson, I consider that the road surface and speed limit at the collision location were likely contributing factors resulting in Stefan losing control of his vehicle.

## RECOMMENDATIONS

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

a) That the Department of Transport and Planning review the relevant portion of Healesville – Koo Wee Rup Road at Yellingbo and consider whether (a) repairs and improvements need to be made to the road surface, (b) safety/warning signage should be erected at the location, and (c) the speed limit should be reduced.

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

Pursuant to section 73(1A) of the Act, I order that this finding is published on the Coroners Court of Victoria website in accordance with the rules.

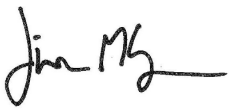
I direct that a copy of this finding be provided to the following:

Easton Legal on behalf of Dalreen Ragel & Gorden Barthelot, Senior Next of Kin

Jeroen Weimar, Secretary to the Department of Transport and Planning

Leading Senior Constable Gareth Curran, Coronial Investigator

Signature:




Coroner Simon McGregor

Date: 18 November 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.