IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001800

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	John David Hogarth
Date of birth:	6 June 1964
Date of death:	29 March 2024
Cause of death:	1a: Injuries sustained in a motorcycle incident (rider)
Place of death:	2km East of Gordon on Western Freeway Ballan Victoria 3342
Keywords:	Motorcycle collision, experienced rider

INTRODUCTION

1. On 29 March 2024, John David Hogarth was 59 years old when he died in a motor vehicle accident. At the time of his death, John lived at 2 James West Street, Glen Waverley, Victoria.

2. John was born in Brunswick and was one of nine siblings. He grew up in the Broadmeadows area, where he met his lifelong friend Peter Burns.[1] His working life mainly involved professional painting with the family business until he moved into hospitality in hotels, and finally into setting up trade exhibitions and conferences at the Exhibition Centre. He was seriously injured in that work in the early 1990s and was on a disability pension from that time onwards.[2]

3. John was a highly experienced motorcycle rider. As a child he loved bicycles, and this interest advanced to motorcycles when he was a teenager. He owned many motorcycles over his 40-plus years of riding and had a particular love of Harley Davidsons.[3] He had purchased the blue 2008 Hardley Davidson Ultra Classic Electra Glide motorcycle he was riding on the day of the collision in March of 2024.[4] The motorcycle was roadworthy[5] and registered.[6] John held a full motorcycle licence and had no traffic infringements recorded in the past 24 years.[7]

4. John had a cheeky charisma, which charmed his many friends from all walks of life and his large extended family. He liked talking to them all and helping them whenever he could. He never had children, but when he was 50 years old he travelled to visit a friend in Vietnam, where he met Ms Quyen Nguyen, with whom he was happily partnered for his last nine years. He returned to Melbourne approximately two years before his passing to help look after his sister, Cathy, and he and Quyen stayed in daily contact over the phone and Facetime.[8]

THE CORONIAL INVESTIGATION

5. John'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.

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[1] Statement of Cathryn Close, Coronial Brief.
[2] Statement of Cathryn Close, Coronial Brief.
[3] Statement of Cathryn Close, Coronial Brief.
[4] Statement of Cathryn Close, Coronial Brief.
[5] Exhibit 6 - Vic Roads Certificate of Roadworthiness, Coronial Brief.
[6] Exhibit 3 – VicRoads Certificates as to Registration, Coronial Brief.
[7] Exhibit 2 - VicRoads Licence Extract and Exhibit 4 – Traffic Infringement Priors, Coronial Brief.
[8] Statement of Cathryn Close, Coronial Brief.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of John'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.

9. This finding draws on the totality of the coronial investigation into the death of John David Hogarth 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.[9]

10. In considering the issues associated with this finding, I have been mindful of John'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

11. At about 5:10 pm on Friday 29 March 2024, John was riding his blue 2008 Hardley Davidson Ultra Classic Electra Glide motorcycle east along the dual lane Western Freeway, just outside of Ballan, heading towards Melbourne. He was riding in company with Peter Burns, who was

[9] 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.

on his own black Honda 750 motorcycle. Both riders were in the left-hand lane, approaching the Ballan exit.[10]

12. John was riding behind Peter, when another motorcycle ridden by Roy Leyshan approached the two riders from behind. Mr Leyshan moved up beside John in the right-hand lane, travelling at about 110 km/h, and the riders exchanged the thumbs up greeting. Mr Leyshan then moved up in the right-hand lane to alongside Peter's motorcycle. Shortly thereafter, John passed both Peter and Mr Leyshan from the far left side of the left-hand lane and moved 40-50 metres ahead. Peter and Mr Leyshan accelerated to catch up to John and as they got nearer, they noticed John's motorcycle wobbling. John never regained control, wavering between the lanes before he was ejected from his bike, landing under a wire road safety barrier on the left-hand side of the road. His motorcycle continued onward for a short time and then crashed. It did not cross the grassy median strip into the oncoming traffic, and no one else was harmed.[11]

13. Passerby Sinae Wilson stopped to render assistance,[12] and she was then joined by off duty paramedic Julian Esposito, who stayed with John until the ambulance attended. John was initially conscious and able to speak, but had sustained lacerations to his forehead, mouth and fingers. He appeared to be short of breath and was complaining of severe pain to his right shoulder and ribcage.[13]

14. Ambulance Victoria paramedics arrived a short time later and continued emergency medical care, but approximately 30 minutes after the collision, John's condition deteriorated. Despite the best efforts of these first responders, John could not be sufficiently stabilised for helicopter triage, and he passed away at the scene.[14]

15. Police investigators took a series of photographs of the road surface near where John's motorcycle began to wobble, showing it to be in poor condition, with previous repair bumps amid smooth patches. This section has however since been re-surfaced, so there are no further prevention opportunities.[15]

[10] Statement of Peter Burns, Coronial Brief.
[11] Statements of Peter Burns and Roy Leyshan, Coronial Brief.
[12] Statement of Sinae Wilson, Coronial Brief.
[13] Statement of Julian Esposito, Coronial Brief.
[14] Statement of Christopher Barker, Coronial Brief.
[15] Statement of Christopher Barker, Coronial Brief.

16. On the balance of probabilities, the most likely scenario, from a combination of the observed driver behaviour and the documented road conditions, is that John lost his balance after riding over one of these asphalt bumps.

17. Senior Constable Daniel Pearce of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit conducted a mechanical inspection of John's Harley Davidson on 31 May 2024. Though his examination was partially limited due to not being able to start the engine, Senior Constable Pearce found no faults, failures or conditions that could have caused or contributed to the collision.[16]

18. The weather at the time of the collision was sunny, the temperature was approximately 20° C, the road surface was dry and the signage and lane markings were appropriate.[17]

Identity of the deceased

19. On 29 March 2024, John David Hogarth, born 6 June 1964, was visually identified by his friend of 58 years, Peter Burns. Identity is not in dispute and requires no further investigation.

Medical cause of death

20. Specialist Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine conducted an external examination on 1 April 2024 and provided a written report of her findings the next day.

21. A post-mortem CT scan showed no skull or cervical spine fracture and no intracranial haemorrhage, but there was a left humeral fracture and bilateral posterolateral rib fractures. There was blood in the abdomen around the liver and spleen, and patchy blood around the right kidney. The liver appeared fatty and there was coronary artery calcification, but neither of these features caused death.

22. The external examination revealed numerous abrasions over the back and abdomen, consistent with so-called 'road rash, indicating movement of the body across the road surface. The injuries were more than sufficient to cause death at the scene.

23. Toxicological analysis of post-mortem blood samples identified the presence of diazepam at a low level, and ketamine, lignocaine and ondansetron at levels consistent with use of those

[16] Statement of Daniel Pearce, Coronial Brief.
[17] Statement of Christopher Barker, Coronial Brief.

medications in emergency medical care. No alcohol or other common drugs or poisons were detected.

24. Dr Glengarry provided an opinion that the medical cause of death was 1(a) injuries sustained in a motorcycle incident (rider), and I accept her opinion.

FINDINGS AND CONCLUSION

25. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[18] The effect of the authorities is that adverse comments or findings should not be made unless the evidence provides a comfortable level of satisfaction that an individual caused or contributed to the death.

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

    a) the identity of the deceased was John David Hogarth, born 6 June 1964;

    b) the death occurred on 29 March 2024 at 2km East of Gordon on Western Freeway, Ballan Victoria, 3342, from 1(a) injuries sustained in a motorcycle incident (rider).

    c) the death occurred in the circumstances described above.

27. For the avoidance of doubt, there is not sufficient evidence to establish that any of the riders were exceeding the speed limit at any stage.

28. Having considered all of the evidence, I am satisfied that John lost control of his motorcycle after riding over the asphalt bumps on the freeway surface.

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

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:

Quyen Nguyen, Senior Next of Kin

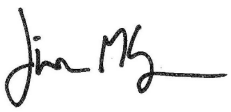
[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

Ian Hogarth, Brother

Ruth Hogarth, Sister

Leading Senior Constable Christopher Barker, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 31 March 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.