IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006535

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Jürg-Peter Styner
Date of birth:	3 September 1966
Date of death:	24 November 2023
Cause of death:	1a: Multiple injuries sustained in a motor vehicle incident (driver)
Place of death:	Patchewollock-Sea Lake Road Speed Victoria 3488
Keywords:	Motor vehicle accident, international tourist driver

INTRODUCTION

1. On 24 November 2023, Jürg-Peter Styner was 57 years old when he died in a head-on motor vehicle accident. At the time of his death, Jürg-Peter was on holiday in Australia, but normally resided at Gallishofstrasse 35 Aeschi 4525, Switzerland, with his wife, Cornelia Styner-Bolliger.

2. Jürg-Peter and Cornelia met while working together in a Swiss post office and had been together for 24 years, marrying in 2004. The couple had four children between them. They both had separate connections to Australia, and their driving holiday here was part of a trip of a lifetime, planned years earlier but interrupted by the COVID-19 pandemic.[1]

3. The couple arrived in Brisbane on 3 November 2023[2] and soon after began touring around Australia in a white 2022 Renault RM20 Winnebago camper van.[3] They received two hours of training in the use of the vehicle and driving on the opposite side of the road before they commenced their journey. The vehicle was relatively new, with only 38,000 km accrued. It had just been serviced and had no known issues.[4]

4. Jürg-Peter and Cornelia's visit to Australia was scheduled to last until 28 February 2024.[5]

5. Jürg-Peter was in generally good health for a person of his age, and held a valid Swiss driver's license.[6] His local doctor informed me that he had hypertension, hypercholesterolemia, hyperuricemia and acid reflux, and was prescribed Lisinopril 20mg and Rosuvastatin 10mg, and Omeprazol 20mg as needed for acid flux. None of these diagnoses nor medications are likely to have materially affected his capacity to control a motor vehicle.[7]

THE CORONIAL INVESTIGATION

6. Jürg-Peter'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.

[1] Statement of Patrick Styner, Coronial Brief.
[2] Statement of Patrick Styner, Coronial Brief.
[3] Statement of SC Daniel Pearce, Coronial Brief.
[4] Statement of Johnathon Symonds, Exhibit 13 - Tax invoice for 1UK3PY service, Coronial Brief.
[5] Statement of Patrick Styner, Coronial Brief.
[6] Exhibit 6 Drivers License, Coronial Brief.
[7] Statement of SC Gillian Avery, Coronial Brief; email from Dr Vicente Vela Garcia dated 26 March 2024.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jürg-Peter's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as eye witnesses, family, the forensic pathologist, treating clinicians, accident reconstruction experts and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Jürg-Peter Styner 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.[8]

11. In considering the issues associated with this finding, I have been mindful of Jürg-Peter'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.

[8] 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

12. In the days prior to the couple's passing, Jürg-Peter and Cornelia had been touring through Victoria's Silo Art trail, viewing various art silos.[9]

13. On 23 November 2023, at approximately 11:20 am, the couple were enroute to view the silo art at Patchewollock. Jürg-Peter was driving, with Cornelia in the passenger seat of the Winnebago. They were heading west on the Patchewollock-Sea Lake Road, approximately 11 kilometres west of the township of Speed, entering into a gentle right-hand curve in the road.[10]

14. At this spot, the Patchewollock-Sea Lake Road is a sealed bitumen, single-lane road in a good condition, intended to accommodate two-way traffic, but with no centre dividing line. The bitumen surface is just under 6 metres wide in total. There are gravel shoulders on both sides of the road to allow vehicles to put wheels off the road surface while oncoming vehicles pass each other. Some parts of the gravel shoulders have a significant drop from bitumen to gravel. Trees and shrubs line both sides of the road, restricting driver visibility in both directions as the road bends.[11]

15. This is an isolated rural area, with large farming paddocks and not much traffic. The default speed limit for the road is 100 km/h.[12]

16. At the same time, Mr Owen Rule was driving the other way, heading east on Patchewollock-Sea Lake Road, driving his fully laden 1999 Kenworth Prime Mover truck and tipper trailer. Mr Rule saw the Winnebago approaching and slowed his truck while moving it to the left onto the northern gravel shoulder as he entered the bend in the road. When he noticed that the Winnebago seemed to be veering towards him, he responded by steering his truck even further to the left, but the Winnebago continued into his path, and collided head on with him.[13] The truck came to rest partially on top of the Winnebago, which sustained catastrophic damage.[14] Cornelia and Jürg-Peter most likely died instantly in the collision.

[9] Exhibit 11 – Travel Itinerary; Exhibit 12 – Data log of Winnebago, Coronial Brief.
[10] Exhibit 12, Data log of Winnebago, Coronial Brief.
[11] Statement of DS Jenelle Hardiman, Coronial Brief.
[12] Statement of DS Jenelle Hardiman, Coronial Brief.
[13] Statements of Owen Rule, Coronial Brief.
[14] Statements of DS Jenelle Hardiman, Coronial Brief.

17. Witness Courtney Jolly was driving a tractor across a nearby paddock on her family farm when she noticed the Winnebago travelling at a slow and steady pace, between 40 to 80 km/h, as it wound down the road. The next time she looked in that direction, she observed a big cloud of dust and realised something had happened. She immediately ran to the scene and called her brother while running. She found Mr Rule attempting to free himself from the cabin of his truck and called 000. A short time later, Ms Jolly's mother also arrived at the scene to assist.[15]

18. Multiple units of police, ambulance, the State Emergency Service and the Country Fire Authority subsequently attended the scene and recovered Jürg-Peter and Cornelia's bodies from the wreckage.[16]

19. Mr Rule suffered injuries requiring air ambulance evacuation to Bendigo Base Hospital, where he provided a blood sample at 2:40 pm pursuant to the *Road Safety Act 1986*. The sample was analysed and did not reveal the presence of all alcohol or drugs other than those administered to him by paramedics.[17] Mr Rule had commenced driving at 8:00 am that morning and his route was part of his regular work taking harvested grain to the storage silos in Speed. He was well rested on this day, in good general health and had a multi-combination endorsement on his full Victorian Driver's Licence, which he had held for the last 34 years. Mr Rule had a good driving record and had never been in an accident before. He was not using his phone at the time of this collision.[18]

20. Mr Rule's driving on the day of the collision was reasonable and appropriate. The collision reconstruction indicates that he was travelling at approximately the speed limit, and that his truck braked for just under 30 metres on the bitumen surface and then for approximately another 60 metres on the gravel shoulder. There were no road marks indicating evasive manoeuvring by the Winnebago. The point of impact was found to be wholly on the northern road shoulder. The collision reconstructionist was unable to determine why the Winnebago crossed onto the incorrect side of the road, but found no evidence that the vehicle was out of control.[19]

21. At the time of the collision the road was dry, the weather was warm and fine, visibility was good other than from encroaching vegetation, and the traffic was light. The road surface at

[15] Statement of Courtney Jolly, Coronial Brief.
[16] Statement of SC Gillian Avery, Coronial Brief.
[17] Statement of LSC Brendan Keegan, Coronial Brief.
[18] Statements of Owen Rule and LSC Brendan Keegan, Coronial Brief.
[19] Statement of DS Jenelle Hardiman, Coronial Brief.

this location was in excellent condition, without potholes or such defects which might have contributed to the collision.[20]

22. Victoria Police Mechanical Investigator Senior Constable Daniel Pearce inspected both vehicles and, though the examination was limited due to the extent of damage, provided an opinion that no relevant mechanical fault, failures or conditions with either vehicle or the trailer caused or contributed to the collision.[21]

Identity of the deceased

23. On 29 November 2023, Jürg-Peter Styner, born 3 September 1966, was identified via forensic odontology comparison. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Specialist Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an autopsy on 30 November 2023 and provided a written report of her findings dated 22 March 2024.

25. The autopsy and post-mortem computed tomography (**CT**) scan showed numerous severe skeletal and soft tissue injuries. Dr Archer explained that the trauma was of a degree and nature seen in high energy incidents and was entirely consistent with the history given of a head-on collision with a loaded grain trunk, with subsequent crush injury. The injuries were extensive, and were of a nature that would have caused rapid unconsciousness and death. She confirmed the injuries were unsurvivable.

26. Dr Archer found no evidence of any natural disease that might constitute an independent cause of death in the organs that were recovered, but noted that the heart could not be located, due to the extent of the trauma.

27. There was no evidence for a toxicological role in the incident. Although post-mortem toxicological testing found a low level of ethanol (alcohol) in spleen blood and vitreous humour, ethanol can be produced after death as part of bacterial fermentation, and it is possible that some or all of the ethanol detected was artefactual. No other common drugs or poisons were detected in spleen blood.

[20] Statement of DS Jenelle Hardiman, Coronial Brief.
[21] Statement of SC Daniel Pearce, Coronial Brief.

28. On the basis of the above findings, Dr Archer 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.

FURTHER INVESTIGATIONS

29. A Fatal Collision Audit was completed by Victoria Police, VicRoads and the Yarriambiack Shire Council after the collision. I commend those parties for this action.

30. On 13 December 2023, the Council indicated their support for the various potential improvements identified during the audit process.

31. By letter to this court dated 17 September 2024, Mr Michael Bailey, Executive Director, Barwon South West Grampians, of the Department of Transport and Planning (**the Department**), confirmed that the vegetation potentially obscuring drivers' views on this section of the road was already under active management by the Department, but that no other changes to the road are currently funded.

32. Without unduly extending the scope of this investigation, I am satisfied that the likelihood of a repetition of this type of collision between tourist and commercial users of this minor road would be reduced by:

    a) reducing the speed limit to 80 km/h per hour on bends which do not qualify for centre line marking by virtue of there being less than 6.2 metres of bitumen road available at that point; and

    b) 'Drive on left side of Road' signs being installed along the increasingly popular Silo Art trail to assist international visitors.

FINDINGS AND CONCLUSION

33. 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.[22] The effect of the authorities is

[22] *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

that adverse comments or findings should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.

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

    a) the identity of the deceased was Jürg-Peter Styner, born 3 September 1966;

    b) the death occurred on 24 November 2023 at Patchewollock-Sea Lake Road, Speed Victoria 3488, from 1(a) multiple injuries sustained in a motor vehicle incident (driver); and

    c) the death occurred in the circumstances described above.

35. Having considered all of the evidence, I am satisfied that the collision that caused Jürg-Peter and Cornelia's deaths was the tragic result of driver error on Jürg-Peter's part in failing to safely accommodate oncoming traffic at a bend in the road.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations that the Secretary to the Department of Transport and Planning:

A. Reduce the speed limit to 80 km/h on the bends on this stretch of road which do not qualify for centre line marking by virtue of having less than 6.2 metres of bitumen road available at that point; and

B. Install 'Drive on left side of Road' signs along the increasingly popular Silo Art trail, so as to assist international visitors.

I convey my sincere condolences to Jürg-Peter'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.

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…'.

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

Patrick Styner, Senior Next of Kin

Paul Younis, Secretary to the Department of Transport and Planning

Melanie Klöti, Suva Accident Insurance

Tania Hui-Nodari, AXA Life Insurance

Senior Constable Gillian Avery, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 18 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.